Provider Billing and Procedure Manual

Revision History

Version	Revision Date	Revision Page Number(s)	Reason	*Reviser*
2.0	Feb. 2005	All	Annual revision	*Publications*
2.1	March 2005	8-15	Added Acronyms	*Publications*
3.0	June 2005	64, 65, 121, 151 - 154	Redaction	*Publications*
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3.2	Jan. 2007	All	2006 annual update	*Publications*
3.3	Aug. 2007	All	2007 annual update	*Publications*
3.4	Dec. 2007	All	Redaction	*Publications*
3.5	July 2008	54 – 57	CO 8766 - Redaction	*Publications*
3.6	Oct. 2008	178 - 182	OHCA ordered	*Publications*
3.7	Dec. 2008	26 – 38, 313	Medical Home updates	*Publications*
3.8	Feb. 2011	74, 77, 82, 89, 90, 95	Redaction	*Publications*
3.9	April 2011	91	Redaction	*Publications*

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Chapter 1

General Information

INTRODUCTION

The Oklahoma Health Care Authority (OHCA) is the state agency responsible for the administration of the Oklahoma Medicaid program. The OHCA has a contractual agreement with Electronic Data Systems (EDS) to be the fiscal agent for the Oklahoma Medicaid program. The OHCA's primary objective is to maintain a system to accurately and effectively process and pay all valid Oklahoma Title XIX Medicaid program provider claims.

This publication is the primary reference for submitting and processing claims, prior authorization requests, remittance advice and other related documents. This manual is not a legal description of all aspects of Medicaid law. This manual is intended to provide basic program guidelines for providers that participate in the Oklahoma Medicaid program.

A provider's participation in the Oklahoma Medicaid program is voluntary. However, providers that chose to participate in Medicaid must accept the Medicaid payment as payment in full for services covered by Medicaid. The provider is restricted from charging the Medicaid member the difference between the usual and customary charge, and Medicaid's payment. Services not covered under the Medicaid program can be billed directly to the member. If there are any instances where the guidelines appear to contradict relevant provisions of the Oklahoma Medicaid policies and rules, the policies and rules will prevail. This manual does not take precedence over federal regulation, state statutes or administrative procedures. The OHCA and EDS developed this manual for Oklahoma Medicaid providers.

The Provider Billing And Procedure Manual will receive periodic reviews, changes and updates. The online version of this manual is the most current version and is available at the OHCA Web site at http://www.okhca.org. Once there, click on Provider, Policies & Rules, scroll down to Guides & Manuals and click on the OHCA Provider Billing & Procedure Manual. Providers issued print and CD copies of this manual will not automatically receive an updated version.

SECTION A: OHCA WEB SITE

The OHCA administers the state of Oklahoma's Medicaid agency program known as "SoonerCare." Primary programs under SoonerCare include: SoonerCare Traditional, SoonerCare Choice and Sooner Plan. The OHCA Web site at http://www.okhca.org (see screen sample 1.1) provides information for Medicaid members and providers with data on programs, and health and medical policies.

Screen sample 1.1

OHCA WEB PAGES

Calendar: The Calendar page can be used to find dates and details on training, meeting and other upcoming events.
Contact Us: Use the Contact Us page to find everything from OHCA addresses and telephone numbers to driving directions to the OHCA office.
Provider: The Provider page has information on becoming a Medicaid provider, provider-type details, claim management tools, program reference resources, rule and policy data, free training opportunities, and updates on what is new in SoonerCare.
Publications: The Publications page has links to most OHCA publications, forms, and OHCA information on statistical reports and data.

SECTION B: GENERAL CONTACT INFORMATION:

OHCA Call Tree
Toll free: 800-522-0114, or in Oklahoma City area: 405-522-6205

Option	Unit	Call Types	Availability
1	OHCA Call Center	Claim status, eligibility inquiries or policy questions	7:30 am – 5:30 pm M-F
2, 1	Internet Help Desk	Internet PIN resets or assistance with Medicaid on the Web	8 am – noon & 1pm – 5 pm M-F
2, 2	EDI Help Desk	Batch transactions assistance	8 am – noon & 1pm – 5 pm M-F
3, 1	Adjustments	Paid claim adjustments or outstanding A/R inquiries	7:30 am – 4 pm M, W, Th, F 12 p.m. – 4 p.m. Tues. (Training)
3, 2	Third Party Liability	Health insurance injury/accident questionnaires, third party insurance inquiries, estate recovery or subrogation issues	8 am – 5 pm M-F
4	Pharmacy Help Desk (issues)	Pharmacy issues	8:30 am – 7 pm M-F 9 am – 5 pm Sat. 11 am – 5 pm Sun.
5	Provider Contracts	Provider contracts	8:30 am – 4:30 pm M, T, Th, F 12:00 pm- 4:30 pm Wed. (Training)
6, 1	Pharmacy Help Desk (authorizations)	Pharmacy authorizations	8:30 am – 7 pm M-F 9 am – 5 pm Sat. 11 am – 5 pm Sun.
6, 2	Behavioral Health Authorization	Behavioral Health authorizations	8 am – 5 pm M-F
6, 3	Medical Authorizations (status)	Medical authorization status	7:30 am – 5:30 pm M-F
6, 4	Medical Authorizations (PA requests)	Prior authorization requests for DME, medical services and emergency PAs for aliens	8 am – 5 pm M-F Closed 10 am – 1 pm Tue.
6, 5	Dental Authorizations	Dental authorizations	8 am – 5 pm M-F

CLAIM MAILING ADDRESS:

EDI Mail tapes, CDs and diskettes to: EDS P.O. Box 54400 OKC, OK 73154	**Form UB-04 (Hospital or Home Health)** Lab or DME (1500) EDS P.O. Box 18430 OKC, OK 73154	**Form 1500** EDS P.O. Box 54740 OKC, OK 73154	***HMO Co-pay/Personal Care*** *(Individual; not agency)* *EDS* *P.O. Box 18500 OKC, OK 73154*
Medicare Crossovers, Dental (ADA form), (1500) EDS P.O. Box 18110 OKC, OK 73154	**Pharmacy** EDS P.O. Box 18650 OKC, OK 73154	**Waiver provider billing for waiver services** P.O. Box 54016 OKC, OK 73154	***Refunding money or returning check*** *OHCA-Finance Unit* *P.O. Box 18299* *OKC, OK 73154*
Sending a written inquiry with copy of claim *OHCA-Provider Services* *P.O. Box 18506* *OKC, OK 73154*	***Long Term Care Nursing Facilities*** *EDS* *P.O. Box 54200* *OKC, OK 73154*	***Claim adjustment request*** *OHCA-Adjustment Unit* *4545 N.Lincoln Blvd* *Suite 124* *OKC, OK 73105*	

Chapter 2

SoonerCare Programs

INTRODUCTION

In order to be eligible to participate in Oklahoma SoonerCare programs, providers must have an approved provider agreement on file with the OHCA. Through this agreement, the provider certifies all information submitted on claims is accurate and complies with all applicable state and federal regulations. This agreement is effective once the provider signs the agreement, and the OHCA reviews and approves the agreement.

SECTION A: PROVIDER POLICIES

A provider is any individual or facility that qualifies and meets all state and federal requirements, and has a current agreement with the OHCA to provide health-care services under SoonerCare or other OHCA-administered medical service programs.

PAYMENTS

Payments to providers under SoonerCare are made for services identified as personally rendered services performed on behalf of a specific patient. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

Payments are made on behalf of SoonerCare eligible individuals for services within the scope of the OHCA's medical programs. Services cannot be paid under SoonerCare for ineligible individuals, services not covered under the scope of medical programs or services not meeting documentation requirements. These claims will be denied or payment will be recouped, in some instances upon post-payment review.

LINK UP TO THE OHCA

For additional information on provider policies, go to www.okhca.org, click on the Policies & Rules link (see Screen Sample 2.1). When the page appears, select the Oklahoma Health Care Authority Medical Rules link and select Chapter 30.

Screen Sample 2.1

SECTION B: PROVIDER FILE MAINTENANCE

Provider agreements must be renewed every three years. It is the responsibility of the provider to maintain records and agreements with the OHCA.

All information changes including address, phone number, bank (including electronic funds transfer data) and group member changes must be promptly reported. Failure to maintain current provider information can result in delay or denial of payments for services rendered. Changes for all provider record information should be in writing and signed by the provider. Please mail your request to:

Oklahoma Health Care Authority
Attention: Provider Enrollment
P.O. Box 54015
Oklahoma City, OK 73154

For additional information on provider enrollment criteria, call the OHCA toll-free in state at 800-522-0114 (option 5), or out of state at 405-522-6205 (option 5). You can also go to www.okhca.org, click on Enrollment, New Contracts and select the appropriate option.

SECTION C: PROVIDER SERVICES

ELIGIBILITY VERIFICATION SYSTEM (EVS)

The EVS system is available from 5 to 1 a.m. Access information by entering the provider's SoonerCare ID number and the alpha-character location code.

The automated voice response (AVR) system provides a nationwide toll free telephone number to help providers obtain pertinent information. Providers are able to enter information on a touch-tone phone or by the AVR speech application.

Available Services
The following is a list of information that can be obtained through the AVR:

- Member eligibility with fax back capabilities.
- Provider warrant information.
- Prior authorization with fax back capabilities.
- Claim status inquiry.

More information regarding the EVS can be found in the Member Eligibility Verification chapter of this manual

EVS Phone Numbers
Nationwide toll free: 800-767-3949
Oklahoma City metro area: 405-840-0650

COMPUTER TELEPHONY INTEGRATION

Computer Telephony Integration (CTI) allows providers to enter information - such as name, provider number and location - through the AVR system. The information is captured and sent to the appropriate provider service coordinator. The provider representative enters notes and questions from the provider into the call tracking system, so if a call must be transferred the provider's information will be captured and available to the next representative.

CALL CENTERS

The OHCA is committed to providing customer service to the provider community, members and other interested parties. OHCA Call Center representatives answer inquiries regarding claim status, eligibility, warrant information, proper billing procedures, prior authorization and SoonerCare policy for providers as well as members. Complex claims and written correspondence are some of the types of inquiries addressed by the OHCA Provider Service Coordinators.

OHCA Services closely interacts with the EDS Provider Relations staff to resolve training issues related to the Oklahoma SoonerCare program. Provider Services and EDS Provider Relations act as intermediaries for providers, members and others by resolving billing or adjudication problems requiring additional information or research.

PROVIDER INQUIRIES

Telephone inquires are received between 7:30 a.m. and 5:30 p.m., Monday through Friday. (Pharmacy Help Desk is available extended hours seven days/week.)

Available Services

Information available to the provider through the call tree options include:

- Claim status.
- Eligibility/EVS.
- Pharmacy Help Desk.
- Provider Contracts.
- Adjustments.
- Third Party Liability (TPL).
- PIN resets.
- Prior Authorization.
  - Medical.
  - Dental.

Before You Call

When calling OHCA Provider Services or the OHCA Call Center, **have the following information available** to expedite the research of the inquiry:

- ✓ The 10-character (nine numbers, alpha character) SoonerCare provider number.
- ✓ The SoonerCare member's ID number.
- ✓ The date(s) of service.
- ✓ The billed amount.

MEMBERS INQUIRIES

When inquiring by telephone, please call between 7:30 a.m. and 5:30 p.m., Monday through Friday.

Phone Numbers

Members toll-free: 800-522-0310
Metro Area: 405-522-7171

Available Services

Information available for the members through the call tree options include:

- Eligibility.
- Claim status.
- SoonerCare Member Services.
- Pharmacy Help Desk
- Enrollment Agent.
- Patient Advice Line, 5 p.m. – 8 a.m. M-F, 24 hours daily on holidays and weekends when Help Line is closed.
- Spanish assistance, 7:30a.m. – 5:30 p.m. M-F.

EDS FIELD CONSULTANTS

EDS has a team of regional field consultants with in-depth knowledge of Oklahoma SoonerCare billing requirements and claim-processing procedures. Training is offered on billing, EVS

and AVR, Electronic Data Interchange (EDI) and Medicaid on the Web Secure Site. Field consultants provide training through on-site visits and workshops. They encourage providers to use electronic claim submission because it's fast, easy to use and saves money.

Training Objectives

The focus of a field consultant is to

1. train newly enrolled providers;
2. contact and visit high-volume providers; and
3. conduct provider training workshops.

Providers may contact their field consultant by telephone to request a visit for training at the provider's location. Field consultants are responsible for arranging their own schedules. They are available Tuesday through Thursday for onsite provider visits. Provider on-site visits are normally scheduled two weeks in advance. Since field consultants are often out of the office, please allow a minimum of 48 hours for telephone calls to be returned.

NOTE*: Field consultants are the last resource for any claim inquiry questions. For claim research or resolution of other Oklahoma* SoonerCare *issues, contact the OHCA Call Center at 800-522-0114 or 405-522-6205.*

Provider Workshops

Field consultants are responsible for the development and presentation of educational workshops about all procedural aspects of the Oklahoma Medicaid Management Information System (OKMMIS).

The OHCA presents scheduled workshops throughout the year to educate providers on Oklahoma SoonerCare claim processing procedures. Workshops are announced in bulletins, newsletters and on the OHCA Web site at http://www.okhca.org. Group training can also be arranged at the request of individual provider groups or associations.

Be Prepared

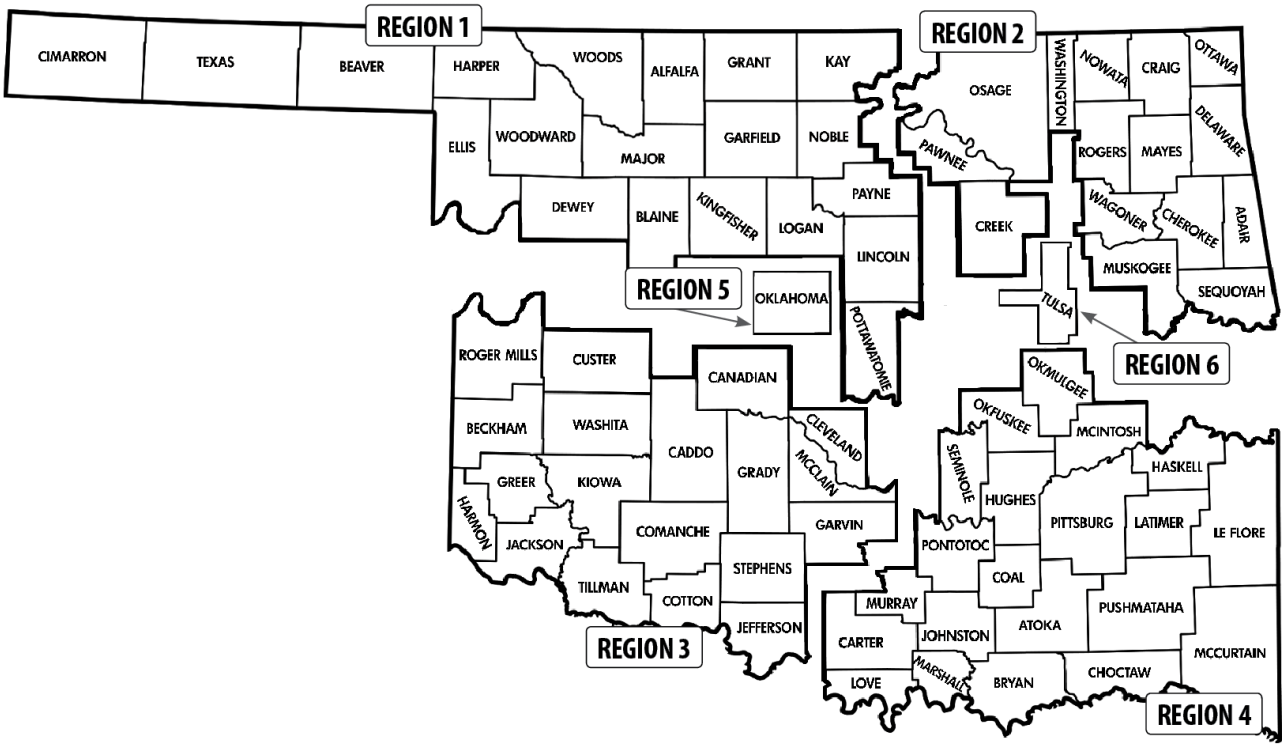
The following information should be provided to assist your field consultant in planning the visit or workshop:

- ✓ Provider type and specialty attending the seminar.
- ✓ Number of attendees.
- ✓ Time and location of the event.
- ✓ Issues to be addressed.
- ✓ Point of contact, in case additional information is needed prior to the event.

HP Field Consultant Representatives Contact Information

Region	Phone Number	Counties within the Region
I	405-416-6715	Alfalfa, Beaver, Cimarron, Dewey, Ellis, Garfield, Grant, Harper, Kay, Kingfisher, Lincoln, Logan, Major, Noble, Payne, Pottawatomie, Texas, Woods, Woodward
II	405-416-6739	Adair, Cherokee, Craig, Creek, Delaware, Mayes, Muskogee, Nowata, Osage, Ottawa, Pawnee, Rogers, Sequoyah, Wagoner, Washington
III	405-416-6720	Beckham, Blaine, Caddo, Canadian, Cleveland, Comanche, Cotton, Custer, Garvin, Grady, Greer, Harmon, Jackson, Jefferson, Kiowa, McClain, Roger Mills, Stephens, Tillman, Washita
IV	405-416-6763	Atoka, Bryan, Carter, Choctaw, Coal, Haskell, Hughes, Johnston, Latimer, LeFlore, Love, McCurtain, McIntosh, Marshall, Murray, Okfuskee, Okmulgee, Pittsburg, Pontotoc, Pushmataha, Seminole
V	405-416-6740	Oklahoma County
VI	405-416-6716	Tulsa County
Out-of-state consultant: 405-416-6730		
Field staff supervisor: 405-416-6768		

Regional Map



MEDICAID ON THE WEB/SECURE SITE

Medicaid on the Web is the OHCA's secure Web site, offering providers a number of services from submitting claims on the Web to fast verification of claim status. New providers are assigned a PIN to access the Web site.

To access the page, go to www.okhca.org, click on the Provider tab and choose Secure Site from the drop-down menu. For more information on logging in for the first time and entering the secure site, look under the Help tab on the Web site. Medicaid on the Web is available from 5 to 1 a.m.

Available Services

The following services are available to Medicaid on the Web users:

- Global messaging (can be specific to one or all providers).
- Claims submission.
- Claims inquiry.
- Prior authorization submission.
- Provider PA notice.
- Prior authorization inquiry.
- Procedure pricing.
- Financial warrant amount.
- Eligibility verification.
- Managed Care rosters.

SECTION D: WRITTEN INQUIRIES

When inquiring in writing about the status of a SoonerCare claim, use the SoonerCare Claim Inquiry/Response form HCA-17. A sample of this form is found in the Forms chapter of this manual. Follow the instructions on the form. Attach a copy of the original claim and any supporting documentation, such as a copy of the remittance/denial, PCP/CM referral, Medicare EOMB, consent forms or medical records required for review.

Mail Inquiry/Response forms, policy questions and any other written correspondence regarding hard-to-resolve SoonerCare claims to:

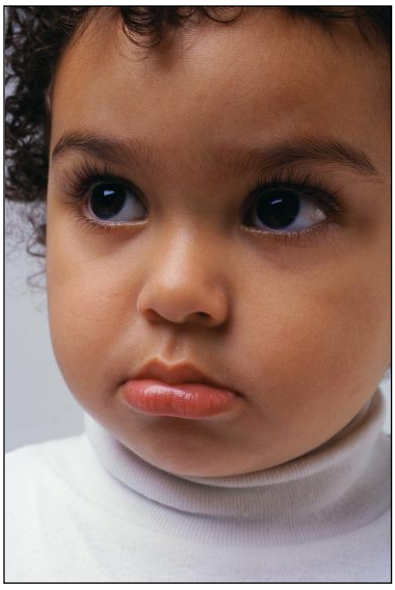
The OHCA
Attention: Provider Services
P.O. Box 18506
Oklahoma City, OK
73154-0506

MAILING CLAIMS

Original, corrected and re-filed claims are submitted to the fiscal agent at the appropriate address listed in the General Information chapter of this manual. Claims mailed to addresses other than the assigned P.O. Box might result in payment delays. For a list of mailing addresses, see the General Information chapter of this manual.

Chapter 3

SoonerCare Choice



INTRODUCTION

SoonerCare Choice is Oklahoma's Medicaid Managed Care program. The program began in 1996 in 61 rural counties in Oklahoma. It was expanded statewide in April 2004 to include urban counties that had been previously covered under the SoonerCare program. The Choice program provides primary and preventive health care services. Health care is provided and managed by a Primary Care Provider/Case Manager (PCP/CM) that contracts to be a medical home for members on their panel. The level of medical home determines the care coordination payment the PCP receives. All other services are pay based on the OHCA current FFS payment methodology. PCP may also qualify for SoonerExcel incentive payments based on individual performance.. Physicians, nurse practitioners and physician assistants in primary care specialties can contract as PCP/CMs.

Quality Assurance

The OHCA is committed to ensuring that high quality health care is always available to its members. SoonerCare Choice providers agree to cooperate with external review organizations, internal reviews and other quality assurance efforts.

Quality Assurance (QA) Tools
Quality assurance measures may include:

CAHPS Report Card
Annual telephone and mail surveys of SoonerCare Choice members are conducted by an external review organization, which measures health care satisfaction, including care provided by their PCP/CM.

After-Hours Surveys
Telephone surveys are conducted by the OHCA or one of its agents to ensure that PCP/CMs provide information concerning after-hours access to medical information or a medical professional.

Member Reports
Member calls to the SoonerCare Helpline for issues regarding quality of care or access to care needs are documented and forwarded to the OHCA for research and/or resolution.

On-Site Audits
On-site audits are conducted by OHCA Quality Assurance/Quality Improvement staff.

Encounter Data Reviews
Data reflecting medical care use rates, preventive care services and referral patterns are reviewed and analyzed. This information is

used in determining use patterns, referral patterns, rate setting and other reporting purposes.

Emergency Room Utilization Profiling
OHCA Quality Assurance/Quality Improvement staff perform quarterly analysis of PCP/CM office encounter claims submission versus emergency room claim submission. The results of these reports are forwarded to the PCP/CMs as well as SoonerCare Provider Services. The goal of this project is to reduce inappropriate use of emergency rooms.

SECTION A: COVERED MEMBERS

The Oklahoma Department of Human Services (OKDHS) determines the eligibility for all SoonerCare members. Members must meet financial, residency, disability status and other requirements before they can become eligible for SoonerCare.

SoonerCare Choice covers members who qualify for medical services through the Temporary Aid to Needy Families (TANF) program or those who qualify due to age or disability. Members may also include women who have been diagnosed with breast or cervical cancer under Oklahoma Cares, or children with disabilities who qualify under the Tax Equity and Fiscal Responsibility Act (TEFRA).

NATIVE AMERICANS

Native Americans who are eligible for SoonerCare Choice must enroll with a Primary Care/Case Manager. They may choose a traditional SoonerCare Choice provider or enroll with an Indian Health Service, Tribal, or Urban Indian (I/T/U) clinic provider that participates in the program. All Native American members have the option to self-refer to any I/T/U facility for services that can be provided at these facilities.

SOONERCARE CHOICE EXEMPT

Most members who are eligible for SoonerCare benefits will be enrolled in the SoonerCare Choice program. Individuals exempt from this mandate are

- eligible for Medicare and SoonerCare Traditional;
- enrolled in a waiver program, (examples being. Advantage or Home/Community waiver);
- residing in a long-term care center or institution;
- enrolled in a private Health Maintenance Organization (HMO); or
- a subsidized adoption.

SECTION B: ACCESS TO CARE

SoonerCare Choice PCP/CMs are required to maintain access to primary and preventive care services in accordance to its contract. The following standards apply:

1. PCP/CMs must maintain 24 hour, seven day per week telephone coverage, which will either page an on-call medical professional or give alternate information to members concerning who they can contact to obtain medical advice. PCP/CMs are allowed to use the SoonerCare Patient Advice Line (PAL) for this purpose during the PAL's operating hours. These hours are 5:00 p.m. to 8:00 a.m. Monday through Friday. The PAL is available 24 hours per day on weekends and state of Oklahoma legal holidays. Please note, the PAL is not intended to replace a PCP/CMs obligation to assess and triage patients during normal business hours.
2. PCP/CMs must offer hours of operation that are no fewer than the hours of operation offered to commercial patients or SoonerCare Traditional members.
3. PCP/CMs must provide medical evaluation and treatment within 24 hours for urgent medical conditions. Generally, urgent care is for sudden illnesses or injuries where there is no immediate danger of death or permanent disability.
4. PCP/CMs must provide routine or non-urgent medical care within three weeks. Routine physicals or chronic conditions that require less frequent care may be excluded from this three-week period.
5. PCP/CMs that provide services to members 18 years old or younger are required to participate in the Vaccines for Children program through the Oklahoma State Department of Health (OSDH) and document immunization data in the Oklahoma State Immunization Information System (OSIIS) database.
   - PCP/CMs can charge a co-payment to choice members.

Emergency Care

PCP/CMs are not required to provide emergency care either in its office or in an emergency room. PCP/CMs that do provide emergency care in the emergency room will be reimbursed based on current OHCA policy.

PCP/CMs should not refer members to an emergency room for non-emergeny services. Providers should interact with its assigned members to discourage inappropriate emergency room use. PCP/CMs should manage follow-up care from the emergency room, as needed.

SECTION C: MEMBER ENROLLMENT/DISENROLLMENT

SOONERCARE CHOICE ENROLLMENT EXCEPTIONS

Exceptions to enrollment in SoonerCare Choice are individuals who are

- enrolled in an HMO;
- in a subsidized adoption;
- in a nursing home or special care center;
- in a home and community-based waiver; or
- eligible for Medicare and SoonerCare Traditional coverage.

SoonerCare member benefits start when DHS determines eligibility for SoonerCare Traditional and certifies the case. The effective date of SoonerCare Choice members' benefits depend on the certification date. Always check the Eligibility Verification System (EVS) either by calling the toll-free EVS line, through the swipe machine or on the Medicaid on the Web Secure Site.

NOTE: *Medical care during the time a member is eligible for SoonerCare Traditional, but not yet effective in SoonerCare Choice, will be covered under the SoonerCare Traditional fee-for-service program.*

Continuing eligibility for SoonerCare benefits must be recertified periodically. The recertification intervals vary according to the type of assistance members receive. SoonerCare members are notified in writing by DHS prior to the expiration of benefits.

Breaks in eligibility may mean a disruption in continuity of care. If the PCP/CM's capacity is limited in comparison to demand, the member may not be able to regain his or her place on that PCP/CM's panel.

Members may reenroll with a PCP/CM by calling the SoonerCare Helpline if they have a break in eligibility and are being recertified. Members who lose and regain eligibility within 365 days are assigned to their most recent PCP/CM, if the PCP/CM has available capacity and is within the PCP/CM's scope of practice.

Choosing a PCP/CM

The OHCA offers all members the opportunity to choose a PCP/CM from the provider directory. If a member does not choose a PCP/CM, the OHCA will contact the member to assist them in choosing a medical home. If a member seeks care prior to choosing a medical home the provider seeing the member will be the medical home.

Families with more than one eligible member are allowed to choose a different PCP/CM for each eligible member.

Enrollment with a PCP/CM takes effect at the beginning of each month. Prior to the first day of each month, the OHCA provides the PCP/CM with a SoonerCare Choice eligibility listing of new enrollees and continuing members.

Capacity (Number of Members requested per PCP/CM)

The PCP/CM specifies the maximum number of members he or she is willing to accept. The maximum number is 2,500 members for each physician PCP/CM. The maximum capacity for physician assistants and nurse practitioners serving as PCP/CMs is 1,250. The PCP/CM must agree to a minimum panel of 50 members. The OHCA cannot guarantee the number of members a PCP/CM receives.

A PCP/CM may request a change in its capacity by submitting a written request to the Provider Enrollement division of the OHCA. If approved, the OHCA will implement the change on the first day of the month with sufficient notice.

If a PCP/CM requests a lower capacity - within program standards and it is approved by the OHCA - the reduction in members will come through members changing PCP/CMs or losing eligibility. Members will not be disenrolled to achieve a lower capacity.

Changing PCP/CMs

The OHCA or the SoonerCare Helpline may change a member from one PCP/CM to another PCP/CM for the following reasons:

- Member can request change without cause.
- When a PCP/CM terminates his or her participation in the SoonerCare Choice program.

Disenrollment At The Request of the PCP/CM

The OHCA may also change a member from the assigned PCP/CM to another PCP/CM for good cause and upon written request of the assigned PCP/CM. If the request is a good cause change, the OHCA will act upon the request within 30 days of receipt from the OHCA SoonerCare Choice division.

Good cause is defined as:

- Non-compliance with PCP/CM's direction.
- Abuse of PCP/CM and/or staff (includes disruptive behavior).
- Deterioration of PCP/CM- member relationship.
- Three no-show appointments.

The dismissal request and supporting documentation should be forwarded for processing to SoonerCare at 405-530-3228. Members may not be notified by the PCP/CM until approval for disenrollment is granted by the OHCA.

Either party has the right to appeal the decision to the administrative law judge, pursuant to OAC 317:2-1-2 (the Authority's Grievance Procedure)

SECTION D: REFERRALS

SoonerCare Choice referrals

- are made on the basis of medical necessity as determined by the PCP;
- are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP/CM; and
- must have the correct provider referral number to ensure payment to the "referred to" provider (provider/referral numbers are site specific).

Referrals must be signed by the PCP/CM or a designee within the PCP/CM's office who is authorized to sign for the provider.

Some services may also require prior authorization. It is up to the "referred to" provider, or provider ordering services, to obtain prior authorization as needed. Prior authorization for services is obtained through the Medical Authorization Unit at OHCA.

SoonerCare Choice referrals must be made if the member requests a second opinion when surgery is recommended. Following the second opinion, any treatment received by the member is to be rendered by the PCP or through a referral made by the PCP/CM.

SoonerCare Choice referrals may be made to another PCP/CM for services equal to those of a specialist. Examples of this are, a family practitioner could refer to another family practitioner who performs a surgical procedure, or a general practitioner could refer to an internist who manages complicated diabetic patients.

SoonerCare Choice referrals may be made to a provider for ongoing treatment for time specified by the PCP/CM, but limited to 12 months. For the duration of the referral, the referred-to provider will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

SoonerCare Choice referrals are not required for

- child physical/sexual abuse exams;
- services provided by a PCP/CM for members enrolled or assigned to the PCP/CM;
- emergency room care;
- obstetrical care;
- vision screenings for members younger than 21 years;

- basic dental for members younger than 21 years (benefit is limited to emergency extractions for members older than 21 years);
- behavioral/mental health;
- family planning;
- inpatient professional services;
- routine laboratory and x-ray; or
- services provided to Native Americans in a tribal, IHS or Urban Indian Clinic facility.

Payment of Referred Services

Payment for referred services is subject to coverage limitations under the current SoonerCare reimbursement policies. Payment for referred services are limited to four specialty visits per month for adults older than 21 years. Visits to their PCP are excluded from this limitation. To ensure payment, PCP/CMs must refer only to SoonerCare providers that have an active SoonerCare Traditional contract.

Documenting the Medical File

Documentation in the medical record should include a copy of each referral to another health care provider and any additional referrals made by the referred-to provider when this information is known. An example might be ancillary services.

Documentation in the medical record should include a medical report from the referred-to provider. The referred to provider should report its findings to the referring PCP/CM within two weeks of the member's appointment. In the event a medical report is not received within a reasonable time, the PCP/CM should contact the referred-to health care provider to obtain this information.

Unauthorized Use of Provider Number

Unauthorized use of a SoonerCare Choice NPI number may result in official action to recover unauthorized reimbursements from the billing provider.

Referral Form and Instructions

In the SoonerCare Choice program, the PCP/CM is responsible for providing primary care and making specialty referrals. The PCP/CM completes the referral form, including the referral number. The PCP/CM's SoonerCare Choice NPI number serves as their referral number. The provider/referral number is site specific and must be for the site where the member is enrolled or assigned. The referral includes ancillary services rendered, or required, by the "referred to" specialist.

With the PCP/CM's approval, a specialist may relay a copy of the original referral to other specialists with instructions considered necessary for proper member treatment. Payment is subject to the current SoonerCare reimbursement policies.

The provider mails the original of the completed form to the specialist, or "referred to" provider. A copy of the form is retained in the patient's medical record.

When a claim is submitted by a "referred to" provider, the referral number must be entered in box 17a of the 1500 claim form, or box 30 of the UB-04 hospital claim form. A copy of the referral should not be attached to the claim. If the referral number is not on the claim form, payment will be denied unless for self-referred services.

Referral forms can be accessed and printed from the Forms page on the OHCA Web site at www.okhca.org.

SECTION E: EPSDT

Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program and one of the highest priorities of the SoonerCare Choice program. EPSDT is designed to provide a comprehensive program of preventive screening examinations, dental, vision, hearing and immunization services to SoonerCare Choice members age 20 or younger.

Schedule of EPSDT Services

As a minimum, the following schedule for EPSDT screening is required:

- Six visits during the first year of life.
- Two visits in the second year of life.
- One visit yearly for ages two through five.
- One visit every other year for ages six through 20.
- Metabolic lead screen at ages one and two; or six years old if not done by age 2. *This is mandatory*.

Additional Requirements

The OHCA requires contractors to:

- Conduct and document follow-up appointments with all members younger than 21 years old who miss appointments.
- Administer outreach, including telephone calls or printed notification mailed to a member when a health care screen is indicated or missed. This ensures that all members who are age 20 or younger are current.
- Educate families of members age 20 or younger about the importance of early periodic screening, diagnosis and treatment.

EPSDT Bonus Payment

The OHCA offers bonuses paid to PCP/CMs that demonstrate a specified screening rate.

To qualify for the EPSDT bonus, verifiable encounter claim data must be submitted in a timely manner as set forth in the SoonerCare Choice contract (Section 6.2 for year 2007) and for any following contract addendums.

The OHCA may conduct onsite chart audits.

See the Reimbursement section below for further bonus payment details.

SECTION F: REPORTING REQUIREMENTS

Data, information and reports collected or prepared by the PCP/CMs in the course of performing its duties and obligations as a PCP/CM are owned by the state of Oklahoma. The OHCA and other appropriate entities reserve the right to examine this information upon request. This information includes medical and financial records, accounting practices, and other items relevant to the provider's contract.

The PCP/CM is required to report to the OHCA in writing and within a timely manner any changes to its SoonerCare Choice contract. The report must include demographic, financial and group composition information as reported in their contract.

Claims submitted by the PCP/CM should be submitted in the same manner and on the same claim forms used to submit claims for SoonerCare Traditional members. Encounter Claims must be submitted within 60 days from the date of services. Denied claims must be corrected and resubmitted within 60 days of adjudication.

SECTION G: REIMBURSEMENT

CHANGE TO CARE COORDINATION

SoonerCare Choice PCP/CMs are paid a care coordination payment for each member enrolled with them on a monthly basis.

Care Coordination payments vary according to the type of members the PCP services and their level of medical home status.

Care Coordination payments are made by the 10th working day of each month for all eligible members enrolled with the PCP/CM on the first of each month. A single monthly payment is generated and accompanies the Care Coordination Listing or is deposited directly.

CLAIMS

PCP/CMs are required to file a claim with the OHCA each time a service is provided to a member. Claims filed will be paid subject to the current SoonerCare Traditional fee schedule and reimbursement policies.

Claims are to be submitted on a 1500 claim form within 60 days of the date the service was provided.

TANF STOP LOSS

To limit risk to PCP/CMs, a threshold of $1,800 per year in capitated services ($450 per quarter) is established by the stop-loss for members eligible through TANF. This is based on the SoonerCare Traditional fee schedule allowables; not gross charges.

IMMUNIZATION INCENTIVE PAYMENT

Immunization Incentive Payments are available when the PCP/CM provides written notice that it has administered the 4th dose of DPT/DTAP to a member before the member's second birthday.

SECTION H: PROVIDER RESOURCES

SoonerCare Choice PROVIDER REPRESENTATIVES

1. SoonerCare PCP/CMs and all other SoonerCare providers have provider representatives to answer questions or policy issues, research complex claim issues and provide onsite training and support. These provider representatives can be reached by calling toll free at 877-823-4529, option 2. Provider representatives will be available to assist you with questions, claim resolution or directing you to your on-site provider representative.

EDS Field Consultants

EDS field consultants make onsite visits to assist providers with billing questions and train providers to summit online claims through the OHCA Web site. The field consultants conduct bi-monthly training sessions along with the spring and fall workshops. Providers can locate their EDS field consultant by visiting the OHCA Web site at www.okhca.org. Once there

1. click on the Provider link in the center of the page;
2. click on the Training link under the Providers header on the left side of the next page; and
3. click on the EDS Field Consultants link on the right of the next page where you will find your field consultant.

Patient Advice Line

The Patient Advice Line is a service available only to SoonerCare Choice members.

Audio Tape Library

The Member Handbook lists a few of the more than 1,100 recorded topics accessible on the Patient Advice Line.

SoonerCare Choice Patient Advice Line

- is accessible Monday through Friday, 5 p.m. to 8 a.m., 24 hours on weekends and state of Oklahoma legal holidays;
- offers triage services to members based on nationally recognized triage protocols; and
- is staffed by registered nurses.

After Hours

Your after hours recording may instruct your SoonerCare Choice members to call the Patient Advice Line; however, the Advice Line serves as a supportive program and is not a replacement for after-hours provider coverage.

The Patient Advice Line offers assistance in determining if the caller has an emergency or urgent care need and educates the caller on home care.

ER Visit Notification

If the Patient Advice Line directs the member to seek emergency room care, your office and the SoonerCare Division of the OHCA will receive fax notifications the next business day.

SoonerCare Choice Patient Advice Line
Toll-free at 800-530-3002
Hearing impaired, dial SBC Relay Oklahoma at
800-722-0353 (TDD/TTY)

Translation Services

The SoonerCare Helpline offers translation services 24 hours a day, seven days a week. If you cannot communicate with the member because of language, call the SoonerCare Helpline at 1-866-872-0807 and enter state code 53510.

The Patient Advice Line (PAL) is available for translation services from 5 p.m. to 8 a.m. weekdays and 24 hours per day on weekends and state holidays. Please call PAL at 800-530-3002 for assistance during these times. The PAL contract with AT&T's translator service accommodates more than 140 languages and dialects. Physicians with a SoonerCare Choice member who does not speak English can use this service during the member's office visit. They can also connect with this service any time a non-English speaking member calls.

CARE MANAGEMENT

The Care Management Department is comprised of registered nurses and licensed practical nurses. These medical professionals

assist in facilitating medical services for SoonerCare members with complex medical conditions.

Care Management Services

- help members access care and services;
- assist providers with coordination of discharge planning;
- resolve issues and concerns with providers as related to medical care;
- help get approvals for medicines and medical services;
- provide patient education to identified groups;
- assist with coordinating community support and social service systems; and
- offer out-of-state referrals if no comparable in-state services are offered or in cases of urgent care needs.

Complex medical conditions include

- high risk OB cases;
- transplant cases;
- catastrophic illness or injury;
- women enrolled in the Breast and Cervical Cancer (BCC) program; and
- children receiving in-home Private Duty Nursing services (includes periodic home visits to evaluate & certify medically necessary services).

Quality Assurance oversees issues with

- Care Management Referral forms;
- high service utilization;
- medical regimen noncompliance;
- inappropriate ER visits;
- multiple providers/pharmacies;
- scheduled medication requests;
- refusing alternate treatments/prescriptions;
- refusing pain management referrals; and
- drug seeking behaviors.

Chapter 4

Member Eligibility Verification

INTRODUCTION

The OHCA contracts with the Oklahoma Department of Human Services (OKDHS) to determine Medicaid SoonerCare eligibility using federal and state eligibility criteria. Most Medicaid SoonerCare criteria related to income levels are determined by the federal poverty guidelines established by the U.S. Department of Heath and Human Services. Visit the Oklahoma Department of Human Service Web site at http://www.okdhs.org/programsandservices/health/ to obtain additional information on member enrollment in medical services.

SECTION A: MEMBER ID CARD

Medicaid SoonerCare members receive a permanent plastic identification card. The Medicaid Medical ID card is a white card with brown and green graphics. The card can be used for accessing the EVS system or a commercial swipe machine system to verify a member's eligibility before providing a Medicaid SoonerCare service. Shown below is an example of the medical ID card.

Members are encouraged to keep their card with them at all times; however, this card is not required to be provided by the member to receive services. Eligibility can be verified by using the member's ID number from their card, member's Social Security number with member's date of birth, member's first and last name along with date of birth or the member's DHS case number; leaving off the 2-digit person code. It's the provider's responsibility to verify the member's eligibility on a per visit basis to ensure the member's continued eligibility for Medicaid SoonerCare coverage. Failure to verify eligibility prior to rendering services could result in a delay or denial of payment.

SECTION B: OPTIONS TO VERIFY MEMBER ELIGIBILITY

As an Oklahoma Medicaid SoonerCare provider, it is imperative that the member's eligibility is verified before providing any services. Providers can check a member's eligibility using one of

four sources: Eligibility Verification System (EVS), the secure Web site, swipe machines or Electronic Data Interchange (EDI). The purpose of the ID card is to give sufficient information to verify eligibility of the member. The card by itself is not a guarantee of eligibility. Providers need a Personal Identification Number (PIN) to access the Oklahoma Medicaid secure Web site and the EVS. If a provider forgets their PIN, they can obtain it by calling the Security Help Desk toll free at 800-522-0114 or within the Oklahoma City metro area at 405-522-6205 and selecting options 2 then 1.

EVS/AVR

The EVS provides a national toll-free telephone number to help providers obtain member eligibility, third party liability (TPL), warrant, prior authorization and claim inquiry information. Providers can also request prior authorization and eligibility fax backs. There are two ways to use the EVS system. A caller may use the touch-tone system or the automated voice response (AVR)/speech recognition system. A PIN is required to access member eligibility information. The four-digit PIN expires every six months. Providers may reset their PIN by staying on the phone and following the prompts.

Touch-Tone System

The touch-tone system allows a caller to go through the call by using the telephone's number pad. The caller's telephone must have touch-tone capability, as rotary style phones will not work on the touch-tone system.

Alpha Conversion

Entering the provider's SoonerCare ID number can access eligibility information. This will be a nine-digit number and the one alpha character location code that was assigned by the OHCA. A location conversion code has been established for the alphabet to be used in conjunction with the EVS. The codes are patterned to coincide with the location of numbers and letters on a telephone keypad. For example, the letter *A* converts to *21. The number 21 represents the second button and the first letter on the second button of the telephone keypad. The letter *R* converts to *72, representing the seventh button, third letter. See the alpha conversion chart below.

Alpha Conversion Chart for EVS

A=*21	F=*33	K=*52	P=*71	U=*82	Z=*12
B=*22	G=*41	L=*53	Q=*11	V=*83	
C=*23	H=*42	M=*61	R=*72	W=*91	
D=*31	I=*43	N=*62	S=*73	X=*93	
E=*32	J=*51	O=*63	T=*81	Y=*93	

AVR/Speech Recognition

Providers without a touch-tone phone can access information using the AVR. The AVR system allows a caller to use a speech application. By speaking into the phone, a caller is able to use the system to get all the information they need. The system is available seven days a week from 5 a.m. to 1 a.m.
Nationwide Toll Free: 800-767-3949
Oklahoma City Metro Area: 405-840-0650

Secure Site Eligibility Verification

Providers have the ability to verify member eligibility through the Secure Web site. They do this by logging into the secure site and clicking on the Eligibility tab. The member may use his or her ID number, Social Security number with date of birth, the member's first and last name along with date of birth or the DHS case number to check eligibility. This must be combined with the "from" and "to" dates of service. Arrow buttons next to the date-of-service fields activate a calendar pop-up feature to aid in selecting dates. The resulting data appear below the search criteria. When searching eligibility on the secure Web site, the Web site will display a verification number and a status of A or N. The verification number and the status do not reflect the member's eligibility. The member's eligibility information is listed under the section titled "Eligibility". Checking eligibility on the secure Web site will also give Third Party Liability (TPL) and Medicare coverage information.

Swipe Card

This device, similar to a credit card machine, hooks into a phone jack. The provider swipes the Medicaid SoonerCare ID card through the reader, which reads the magnetic strip. The eligibility information is displayed on the screen or printed on a paper slip. Providers interested in the swipe card option can contact a third party vendor for details.

Electronic Data Interchange (EDI)

EDI is a way for providers to check eligibility on a larger scale than the previous options. Providers purchase third party, HIPAA compliant software used to send a 270 transaction with their search

criteria and receive a 271 response, which provides eligibility information. A 271 will give providers information on the different programs the member has as well as any TPL or Medicare information.

Chapter 5
Web/RAS

INTRODUCTION

The OHCA secure site is one of the most exciting features of the Oklahoma Medicaid Management Information System (MMIS). The efficiency and convenience of the Internet remote access server (RAS) gives all Oklahoma SoonerCare providers fast access to member and provider specific information. Any SoonerCare provider can access the Web/RAS with its Provider ID and an OHCA-generated personal identification number (PIN). Once the provider has established a free account, they can create new clerks and grant each clerk role-specific access. The Web/RAS is always available.

IMPORTANT WEB SITE NOTES:

- User names and passwords are case sensitive.
- All dates should be entered in MMDDYY format.
- Dollars and cents should be separated by a decimal.
- Line totals will not be calculated automatically; the user must multiply the units by the unit rate to ensure the correct total billed amount.
- Do not populate the TPL amount unless another payer has paid a specific amount toward the claim.
- Decimals should not be used when entering diagnosis codes.

SECTION A: ACCESSING THE SECURE WEB SITE

The secure Web site can be reached through the public Internet. All that is required are

- Microsoft Internet Explorer browser version 6.0 or higher
- 128 bit encryption; and
- customized security settings to access information across domains.

Windows 98 users will need Microsoft updates. For more information on required updates, please contact EDS Internet Help Desk.

GETTING TO THE SECURE WEB SITE

1. Go to www.okhca.org.
2. Under the Provider header in the center of the screen (see Screen Sample 5.1), click on the "Secure Site" link to get to the OHCA secure site.

Screen Sample 5.1

NOTE: *On the OHCA Web site, providers have complete access to all the latest Oklahoma Medicaid related information and updates.*

LOG ON PAGE

The Log On page serves as the access point for all Internet users. Users will begin account initialization and log on from this page, once accounts are established.

Screen Sample 5.2

ACCOUNT INITIALIZATION

A user will go through an initialization process the first time they log on to the secure site (see Screen Sample 5.2). This will differ depending on the security level of the user.

LOGGING ON

1. Enter the secret ID specific to your role:

Providers - Under 'First Time Here,' enter the Provider ID number in the Log On ID field. This does not include the service location alpha character. (i.e. 123456789).

Billing Agents – Under 'First Time Here' enter the submitter ID given to you by EDI in the Log On ID field.

Clerks – Under 'Already a Member' enter the name generated by your provider or billing agent. Enter the password in the Password field and skip Step 2.

2. Enter the 9-character PIN in the PIN field.
3. Click the Log On button at the bottom of the page.
4. After clicking logon a popup window will appear called the OHCA usage security agreement statement. There will be I Agree and I Disagree options at the bottom. Clicking I Agree will take you to the Account Maintenance Screen. Clicking I Disagree will bring you back to the logon page.

NOTE: *This statement will not appear if a popup blocker is on. It will go to the account maintenance screen, which will ask you to save. All popup blockers must be turned off in order to see the popup screen with the Save button.*

4. Enter a user name in the User Name field. The user name must start with a letter of the alphabet and be six to 12 characters.
5. Enter a password in the New Password field. The password must begin with a letter of the alphabet, be six to eight characters and contain no fewer than two numeric characters.
6. Confirm the password by retyping it into the Confirm Password field.
7. Enter a contact name in the Contact Name field. Providers need to enter the clerk's full name.
   Clerks are not authorized to do this.
8. Enter an e-mail address in the E-mail field.
9. Enter phone number in the Phone Number field.
10. Enter two self-authentication questions and answers.
    Clerks only.
11. Click on the Submit button.

If all data was entered correctly, a box will pop up telling you that your data have been successfully saved.

12. Click the OK button.
13. Click on the Save button.
14. Click the Log Out button.

After setting up your user name and password, future login attempts are done at 'Already a member?' by entering the user name in the User Name field and entering the password in the Password field.

TYPES OF WEB USERS

Level 1 (Providers)
Providers will receive a letter by mail containing the provider's access PIN. This PIN, used in conjunction with the Provider ID, will grant the provider initial access to the secure Web site. Only providers with an active SoonerCare contract will receive a PIN letter. Separate PIN letters will be mailed to each location. It is recommended that providers initialize their account and immediately create Level 2 users (clerks) that will be used to operate the Internet application on a daily basis. Operating daily under the Level 1 (Provider) master user poses certain security risks and should only be used when managing the account.

Level 1A (Billing Agents)
Billing agents are given log-on credentials directly from the OHCA. When the users initialize their accounts, they will be forced to establish a password and contact information.

Level 2 (Clerks)
The provider or billing agent that created the clerk will give clerks log-on credentials. Users will be required to establish a password, contact information, and self-authentication questions and answers upon initializing their accounts.

Drug Manufacturers
Drug manufacturers must request online access. A PIN letter will be mailed to the requesting company once the user requests access and the request is approved. Users will establish a password, contact information, and self-authentication questions and answers upon initializing their accounts.

Other
Other users include: The Oklahoma Department of Human Services (OKDHS) and any other agency that intends to access the secure Web site via the public Internet. Internet users of this type will be created by the OHCA administration, and credentials will be given to them. Users will establish a password, contact information and self-authentication questions and answers when initializing their accounts.

FORGOT PASSWORD

Users who forget their passwords may still gain access to the secure Web site through the self-authentication process. The self-authentication process requires the user to change his or her password.

Users Who Forget
Users who forget their password must provide his or her PIN and Provider ID. Valid data will take users to the account maintenance page where they will create a new password. They will go to the secure Web site after the new password is set.

Billing Agents or Clerks That Forget
Billing agents or clerks that forget their passwords can click on the Tab, "Forgot Password?" and answer the two secret questions they set up the first time they logged on. They are then taken to their account maintenance screen to change their password.

SECTION B: WEB FEATURES

The OHCA secure site has many features to help providers with everything related to Medicaid billing. This section will cover several OHCA secure site features.

GLOBAL MESSAGES

This is the first page the user will see after logging on. It will have global messages from the OHCA that can be directed to an individual provider, a specific provider type, or to the entire provider community.

After reading each message, click on the Read box. This will move the message to the Mailbox for future reference until it expires.

After reading all messages, click on the Next button.

MAIN PAGE

The Main page is the user's home page. The Main page shows the User ID and the taxonomy number, provides information about the direction of remittance advices and contains shortcut links to all areas of the Web site.

Drug Manufacturer Main
This Main page is **only available to drug manufacturer users**. It contains a brief description of the features available to drug manufacturers, a phone number to call for questions and a link to the download page.

Switch Provider
The Switch Provider page is **only available to clerks and billing agents**. This feature allows the user to select the provider he or she wishes to access. The provider must grant access to the billing agent or other user through the Account Maintenance page before this functionality is available. To switch to a different provider, click the hyperlink of the desired provider ID found on the Main page. The "Next" button will take the user back to the Main page.

CLAIMS PAGE

The Claims Page facilitates the communication of claim data between the OHCA and the provider community.

Providers without access to HIPAA compliant Practice Management software, a clearinghouse or a virtual access network (VAN) still have the ability to submit claims electronically. Direct data entry (DDE) enables the provider to submit individual claim information electronically to OHCA/EDS without the constraints of having to submit the data in HIPAA compliant format. DDE claim pages are available on the OHCA secure Web site for all claim types (i.e. professional, institutional, dental and pharmacy).

These pages contain separate box/fields where claim data must be populated. As with paper claim forms, box/field population requirements depend on the billing situation. However, if a provider attempts to submit a claim via the DDE page and has not populated all required fields, the system will prompt a pop-up box stating which required fields are unpopulated.

Direct Data Entry processes can only be performed one claim at a time.

Claim Inquiry

Users may inquire about claims already submitted to the OHCA/EDS using client ID, patient account number, internal control number (ICN), status, dates of service and warrant dates. A results box from the search will appear below the search criteria in the form of a summary list. Twenty results will appear at a time with navigation links below the box to view the next or previous list of results from the query. Each summary result item is hyperlinked to the claim detail page in the ICN and hyperlinked to the Client Eligibility page in the Client ID.

Performing a Claim Inquiry:

1. Click on the Claim Inquiry link, or move mouse pointer over the Claims tab, highlight Claim Inquiry and click on it.
2. If known, the client ID number can be entered in the Client ID field.
3. The Claim Status field can be set to, 'Any Status,' 'Denied,' 'Paid,' 'Suspended,' or 'Resubmit'.
4. If the patient account number is known, it can be entered into the Patient Acct. # field.
5. Choose a date type by selecting either the 'Date of Service' or 'Warrant Date' Date Type radio buttons.
6. If known, the ICN can be entered in the ICN field.
7. The from date of service can be entered into the From Date field, and the thru date of service can be entered into the Thru Date field.
8. Click on the Search button.

Claim Submission

Providers need to confirm that they are logged in under the correct provider number location before starting claim submission.

Institutional Claim Submission From this page, users may submit, resubmit, adjust and void institutional claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display in real time below the claim form in the claim status box.	***Professional Claim Submission*** From this page users may submit, resubmit, adjust, and void professional claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display real time below the claim form in the claim status box.
Dental Claim Submission From this page, users may submit, resubmit, adjust and void dental claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display in real time below the claim form in the claim status box.	***Pharmacy Claim Submission*** From this page, users may submit, resubmit, adjust and void pharmacy claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display in real time below the claim form in the claim status box.

Resubmit Claim-Denied Claims Only

1. Pull up 'Denied' claims (from the Claim Status field), along with any other search criteria.
2. Click on the ICN link of the claim that needs correction.
3. Change the information in the field containing the incorrect data and click on the Re-Submit button.

Void Claim-Paid Claims Only

1. Pull up 'Paid' claims (from the Claim Status field), and any other search criteria.
2. Click on the ICN link of the claim that needs to be voided.
3. Click on the Void button. This will create an account receivable for the amount previously paid, which will be deducted from a future warrant.

Copy Claim-Paid Claims Only

1. Pull up 'Paid' claims (from the Claim Status field), along with any other search criteria.
2. Click on the ICN link of the claim that needs to be copied.
3. Click on the Copy Claim button. Make any changes to Client ID number, procedure codes, date of service or any other fields you need changed to make a new claim.
4. Click the Resubmit button.

ELIGIBILITY PAGE

The purpose of the Eligibility page is to verify eligibility of SoonerCare members. To run a query, a valid client ID, Social Security number and date of birth, name or case number lookup are needed. This must be combined with the "from" and "to" dates of service. Resulting data will appear below the search criteria. Calendar buttons next to the dates of service fields will activate a calendar pop-up feature to aid date selection.

Pricing Page

The Pricing page allows users to inquire on pricing information for procedures and drugs through the Internet. Selecting the radio button for Procedure or Drug will change the available options for searching. A drop-down menu is available for the user to select the associated benefit package and all resulting data will be based on that selection. The search results summary will appear in a list below the criteria. This summary will be hyperlinked to a detail page.

Procedure Pricing

The detail page for procedure pricing will display all vital procedural components. A field will only appear if data are present for that procedure. Displayed data may include

- procedure code;
- allowed amount;
- PA requirement;
- maximum units;
- gender requirement;
- attachment requirement;
- lifetime limitation;
- diagnosis; restriction; or
- specialty restriction.

Drug Pricing

The detail page for drug pricing will display all vital data regarding the drug. A field will only appear if data are present for that drug. Data displayed are

- NDC Code;
- EAC;
- MAC;
- PA Requirement;
- maximum units;
- maximum days supply;
- age restriction;
- gender requirement.
- measurement unit for pharmacy claims; and
- measurement unit for non-phamacy claims.

PRIOR AUTHORIZATION PAGE

The prior authorization (PA) windows allow the user to submit new PA requests, to inquire about pending prior authorization requests and to inquire/copy notices.

Prior Authorization Submission

The PA Submission page allows users to request a prior authorization.

The header section requests information about the patient and provider. Enter appropriate information in boxes. Below the header section is a large summary box that alternates between line items, notes and attachments, depending on the user selection to the left of the summary box. Line item boxes are used to enter procedure-code-related details. The Attachments box is used to enter ACNs to facilitate matching with attachments sent to the OHCA. The Notes box is used as a free form text box for additional information from the provider to OHCA prior auth analysts.

The next section consists of detail boxes. The user enters the appropriate information in the detail boxes and clicks the Add button to move the information to the summary box, which clears the detail box or boxes for additional entries. When complete, click the Submit button.

If required information is missing, the user will be prompted to enter that information and click the Submit button again.

Prior Authorization Inquiry

1. Click on the Prior Authorization link, then click on the Status Inquiry link or move the mouse pointer over the Prior Auth tab, and highlight and click on Inquiry.
2. If you have the PA number, enter it in the PA Number field.
3. If you don't have the PA number, you may search for it by entering the client ID number in the Client ID field and enter the assignment code in the Assignment Code field by clicking on the down arrow, highlighting the appropriate choice and clicking on it.
4. You can also search by entering a drug code in the NDC field and/or by entering a date in the Start Date field by typing it in or by clicking on the down arrow to pull up a calendar.
5. Click on the Search button.

A start date can be added to increase the filter. Search results are displayed in a list box of 20 results at a time. If more results exist, they may be viewed by using the Prev. and Next links below the list box. Selecting a result summary line will open the PA detail window.

Prior Authorization Summary

The PA Summary page appears when a user searches a PA using the PA Inquiry page. The header section outlines information about the patient and provider. Below the header section is a section that alternates between line items and notes, depending on the user's selection to the left of the summary box.

Line item boxes are used to review procedure-code-related details and status. The Reason Code section and I.A.C. section also relates to each line item highlighted in the Line Item summary box.

The Notes box is used to review notes entered to an OHCA PA analyst.

Prior Authorization Notices
Go to the Prior Authorization drop-down menu, click on the Notice link and search by one of the following:

- Client ID or member name to access recent PA notices submitted under your provider number for that member.
- PA Number of a specific PA. This will bring up only the notices related to that number.
- Click the Search button and you may view all the PA notices under your provider number.
- Click on Count Summary to access the Notice image number. This will bring up the PA notice letter, which can be printed.

On each column, the provider can click on the up or down arrow that will allow them to sort ascending or descending order.

Additional tidbits for successful use

- When searching by either a specific PA number, client ID, or member name the Date Span fields are auto populated with a 60-day span. The From date counts back 60 days from the Through date. The Through date is the day the research is being conducted.
- The Web program holds a 60-day rolling submission history. For example, if the PA request was entered into the system on 01/01/06, it will be available for online viewing until 03/02/06.
- When logged on to a Group Provider number, the system will bring up PA information for every provider in that group.

On the Main page of the secure Web site, a message has been added that will tell you the number of unread PA notices under this provider log on.

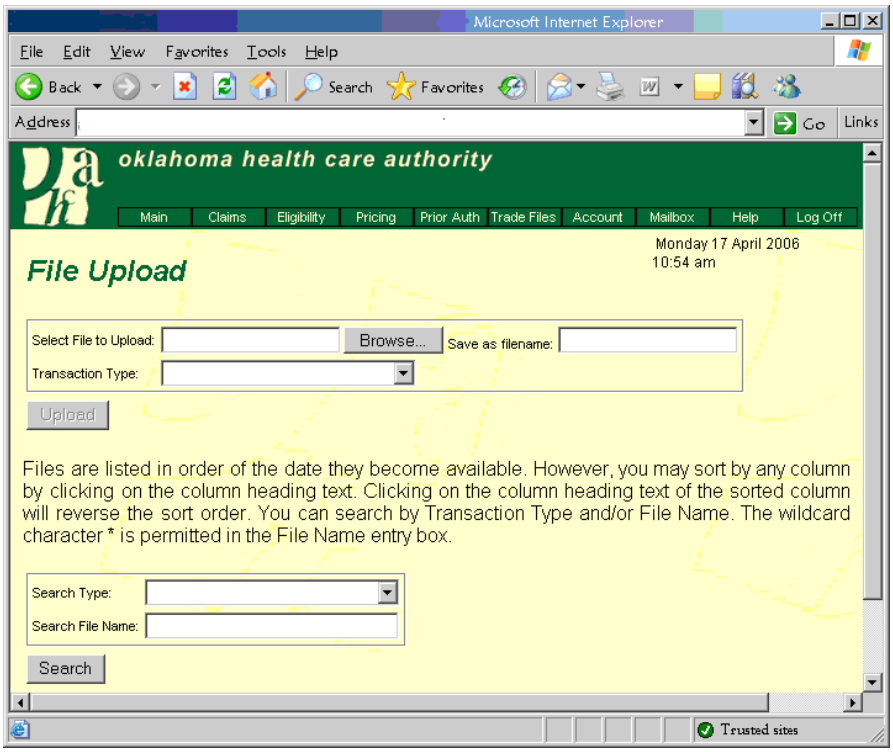
TRADE FILES PAGE (BATCH SUBMISSION)

Trade Files pages are available to providers to facilitate file transfers between the provider community, drug manufacturers, other involved agencies, and the OHCA.

File Upload
The File Upload page allows the user to select a file from a local hard drive and upload it to the OHCA. Users of this feature include

providers that wish to upload batch claim submissions and managed care providers that wish to upload PCP information. Batch upload is an Internet submission option that is available to providers who wish to submit large claim batches or inquiries. To use the Batch Upload option, providers must use HIPAA compliant software or clearinghouse/VANs that can submit required data in HIPAA compliant ANSI X12 Addenda format. Once the provider has ensured the batch claim data have been converted into the corresponding HIPAA compliant format and have successfully completed authorization testing with the EDS-EDI team, they then have the ability to upload an entire batch file/transaction into the Oklahoma Medicaid Management Information System (OKMMIS).

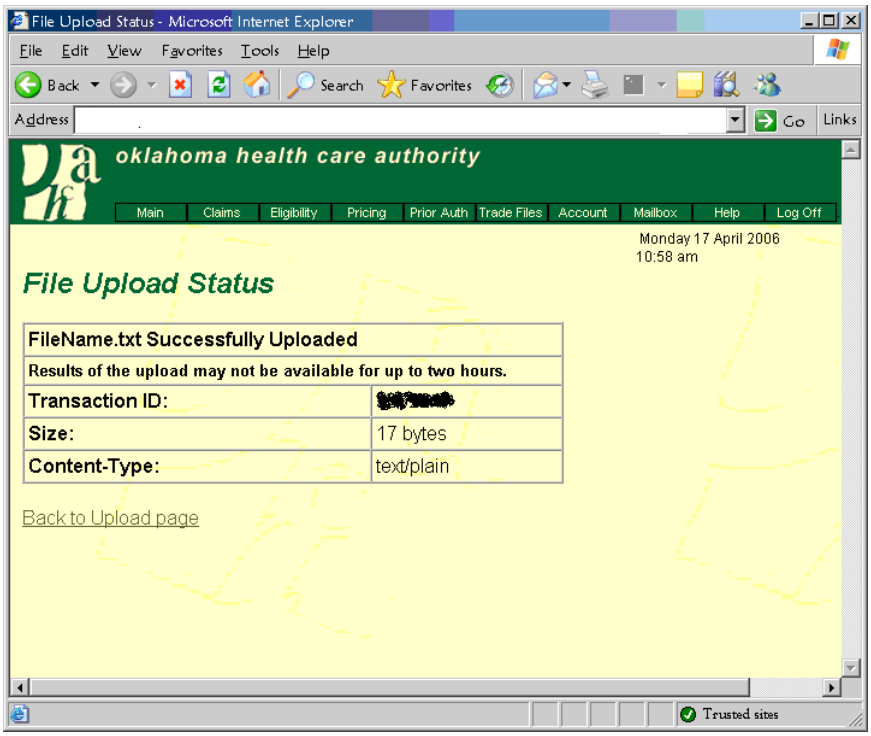
If users wish to upload a batch, they must go to the Trade Files page. Pointing at the Trade Files option and clicking on the Upload feature will take them to the Upload page (Screen Sample 5.3).



Screen Sample 5.3

From this page, the user will need to click on the Browse button to locate the file they wish to upload. The user then has the ability to change the file name in the Save as Filename box. Next, click on the drop-down arrow next to the Transaction Type box and pick the appropriate type that corresponds with their transaction. Once all information is complete, the user clicks on the Upload button.

When the file uploads, the user will see the page stating the upload was successful and the Transaction ID assigned to it (Screen Sample 5.4).



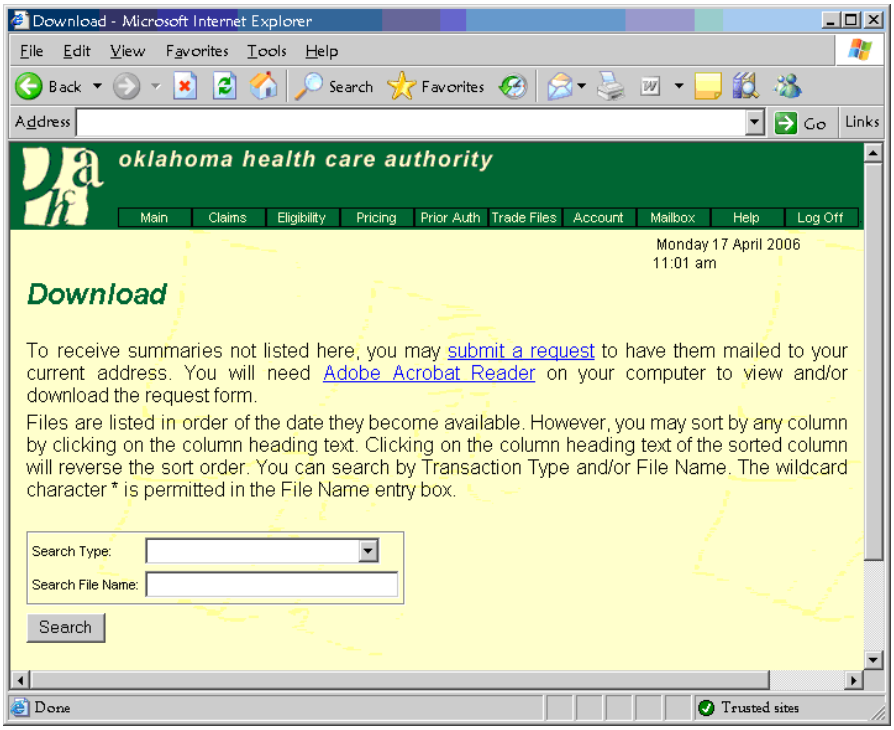
Screen Sample 5.4

The Upload process is now complete for the user. This process must be repeated for all files uploaded via the Web/RAS.

File Download

The File Download page allows the user to select a file from the provider secured Internet site and download it to their system. The available files will be listed as hyperlinked file names. The download process begins when the link is clicked. A compressed or "zipped" file will download to the user's system. Compression software is required to open the file. Users of this feature include providers that wish to download batch claims or response files, drug manufacturers that wish to download their invoices and managed care providers that wish to download managed care roster information.

To download a file (i.e., an 835 Remittance Advice), click on the Download feature. The Download page will open. All files that were created for the specific user/provider will be found on this page (Screen Sample 5.5).



Screen Sample 5.5

To download one of the listed files, click on the file name. It will either begin to download or a dialog box will open, depending on your browser settings. Download the file according to your usual protocol. The file will automatically download with the default name of "getfile.zip" or "getfile.z," depending again on your browser.

NOTE: *If you are downloading multiple files, you will want to extract the file and rename it before downloading another file to avoid replacing the original "getfile" with your new "getfile."*

ACCOUNT MAINTENANCE PAGE

The Account Maintenance page is the first page that users will see when they initialize an account. This page is designed to establish the security credentials for users and clerks, and allows users to update and maintain user account data.

Level I (Provider)

After users access the Web site for the first time and initialize their account, they are brought to this page. Here users will establish their user names, passwords, contact names and phone numbers. The e-mail field is optional. The security level, status and last logged on dates are maintained by the application and are not updateable by Level I users.

Billing Agent or Clerk

Adding a billing agent or clerk is done by clicking the Create New Clerk button. A separate box will appear where the new clerk's information will be entered.

1. In the User Name field, create a generic name (i.e. CLK12345).
2. In the Contact Name field, enter a valid contact name.
3. In the Password field, enter a generic password (i.e. CLK12345).
   NOTE: *The clerk must replace the generic user name and password with desired selections when they logon the first time.*
4. To add all roles, click on the Add All Roles button and skip to Step 7.
5. To add only specific roles, select the role(s) from the list on the right of the screen. To select more than one role, hold the CTRL key while selecting roles.
6. Click on the Grant Role button after selecting the desired role(s). The selected roles appear in the list on the left.
7. To delete a role from the list, highlight the role in the list on the left and click the Cancel Role button. Select the Cancel button to abort the clerk creation process.
8. Click on the Create Clerk button and then the Save button to complete the assignment.

Granting Access to Other Providers of Existing Billing Agent or Clerk

After a clerk or agent is created, he or she will automatically have access to the provider account under which he or she was created. In order for the clerk or agent to access other providers' accounts, access must be granted.

1. Go to the account maintenance section by selecting the Account tab at the top of the page.
2. Key the user name of the clerk or agent to be granted access in the User Name field within the Provider Associations area.
3. To designate the user to receive RAs, rosters, and/or capitation summaries, place a check in the appropriate box(es).
4. Click on the Grant Access To button.
   a. Click on the Edit Clerk Roles button to add roles for the existing clerk.
   b. To add all roles, press the Add All Roles button.
5. To add only specific roles, select the role(s) from the list on the right of the screen (to select more than one role, hold the CTRL key while selecting roles). Click on the Grant Role button.

6. Click on the Update Clerk button when all selections are made.
7. Click the Save button when back on the Account page.

NOTE: *This process must be followed for each provider account to which the clerk or agent needs access.*

Revoking Billing Agent or Clerk Access

When a billing agent or clerk no longer needs access to your provider account, you must revoke his or her account privileges.

1. Log in as the provider and click on the Account tab at the top.
2. Highlight the user name from the list in the box and click on the Revoke Permissions button.
3. A box will appear asking if this clerk should be revoked access to the account. Select the OK button to complete the process or select Cancel to deny the revocation.
4. After selecting OK, click the Save button.

Level IA (Billing Agent)

The Account Maintenance page for Level IA users operates the same as the above Level I in all aspects, except that the Level IA user will be forced to establish self-authentication questions and answers when the account is initialized. These questions and answers may be updated at any time.

Level II (Clerk)

The Account Maintenance page for Level II users operates the same as the above Level IA in all aspects – except that the Level II user does not have the ability to create, grant access to, or revoke permissions of other Level II users.

MAILBOX PAGE

The Mailbox page contains messages from the OHCA directed specifically to certain groups, such as specialties. After successfully accessing the secure Web site, the Mailbox page displays first. The Mailbox will always display any active messages not checked as read. Next to each message is a Read check box. When this is selected, the message will no longer appear at log on. However, the message will still be available by clicking the Mailbox link from the menu and remains in the Mailbox until it expires. The administrator who sends the message determines the expiration date. Below the messages is the Next button. Selecting this button will take the user to the Main page.

HELP PAGE

The Help pages for the secure Web site are dynamic in that the help text that displays is unique to the page that the user is viewing. Help pages also include a button titled, Ask Tech

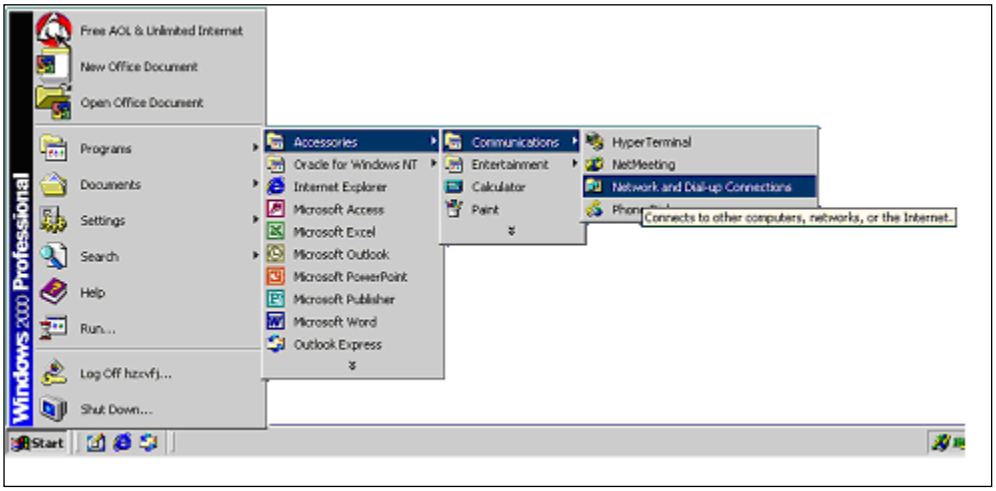
Support. This button opens a page that has a text box for asking a question. When you click Send on this page, the text you typed and the .xml file from the Web page you are viewing is sent to a call support specialist for review.

LOG OFF PAGE

Clicking the Log Off Tab ends your current session on the secure site and directs you to the Log Off page. The Log Off page displays the non-secure menu options. Clicking the Log Back On button will take you to the Log On page.

SECTION C: REMOTE ACCESS SERVER (RAS)

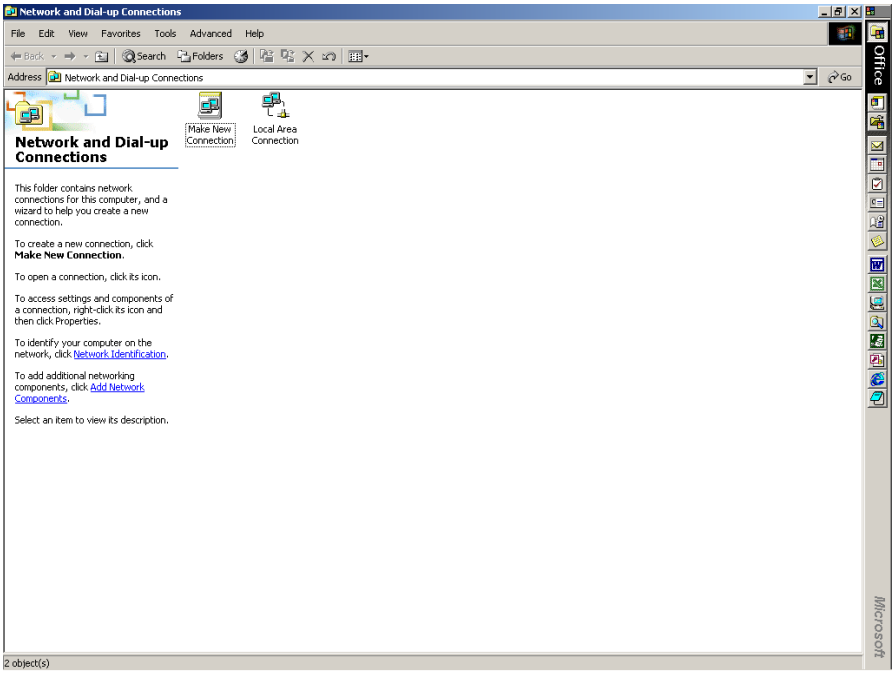
you may use the Remote Access Server (RAS) to submit claims through an existing dial-up connection. The RAS lets providers use all options of OHCA's secure Web site without an Internet service provider. Basic requirements to log on the RAS are an analog phone line, a modem and Internet Explorer 5.0 (or higher).



Screen Sample 5.6

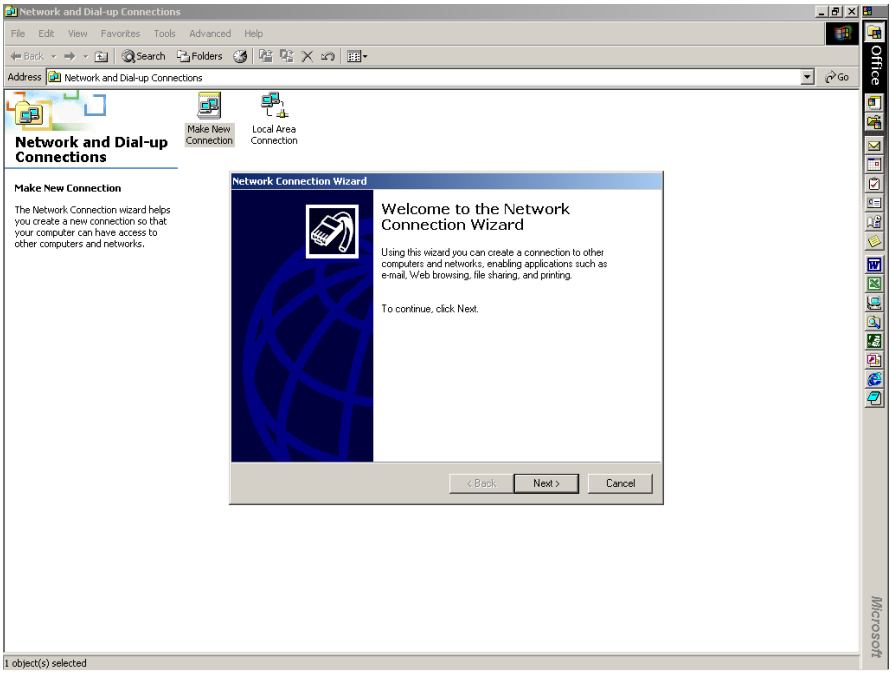
The first step in accessing the RAS is to create a new connection for the Oklahoma Medicaid Remote Access Server (see Screen Sample 5.6). To prompt the Network Connection Wizard

1. click on the **Start** button on the main toolbar;
2. drag mouse up to Programs;
3. drag mouse over to Accessories;
4. drag mouse over to Communications; and
5. drag mouse over to Network and Dial-up Connections and click on it.



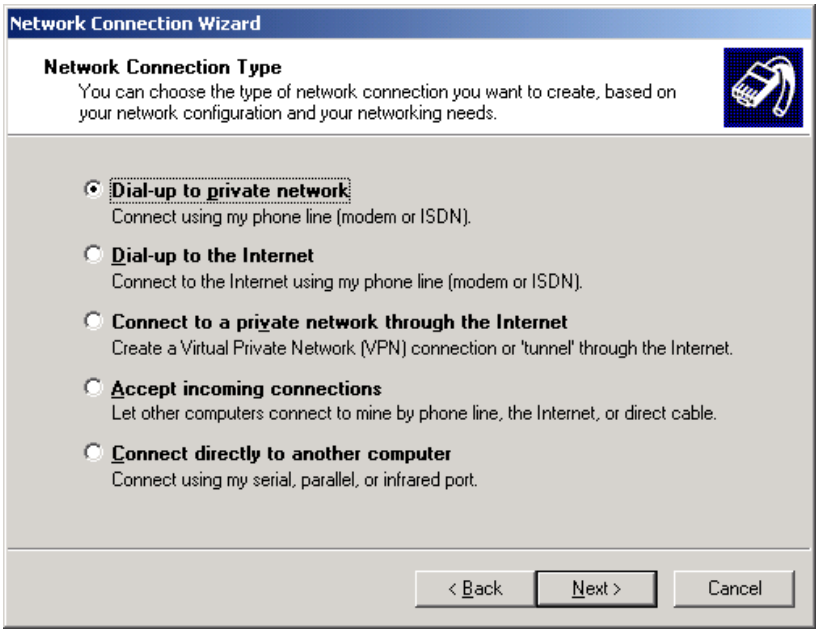
Screen Sample 5.7

Once you have the Folder opened for Network and Dial-up Connections (see Screen Sample 5.7), click on the "Make New Connection" icon to start the Network Connection Wizard.



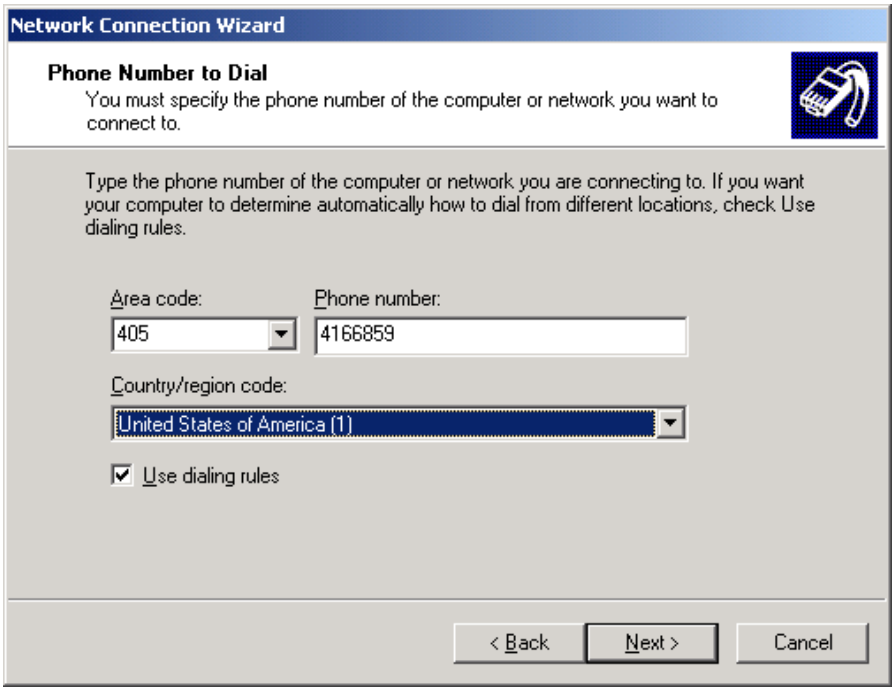
Screen Sample 5.8

Once the Network Connection Wizard has started (see Screen Sample 5.8), this box appears and guides the user through the network creation process. The first step in the setup process is to click Next.



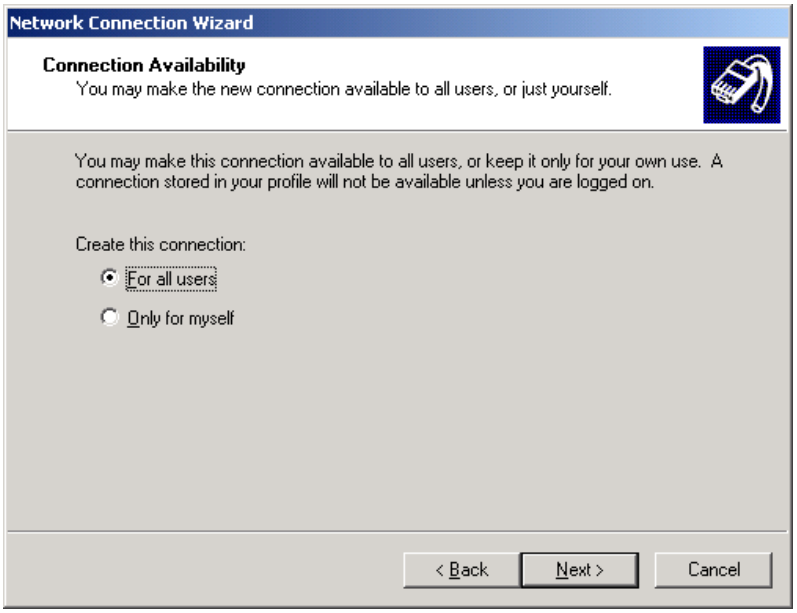
Screen Sample 5.9

In the “Network Connection Type” box, (see Screen Sample 5.9) click on the “Dial-up to private network” option and then click Next.



Screen Sample 5.10

The "Phone Number to Dial" box (see Screen Sample 5.10) prompts the user to type in the actual phone number they will be using for the new connection. The phone number to type in this box is Area Code**:** 405, Phone number: 4166859 (Do not include any dashes in the phone number). Then select "United States of America [1] for the Country/Region code selection and put a check in the "Use dialing rules" checkbox. Click the Next button.



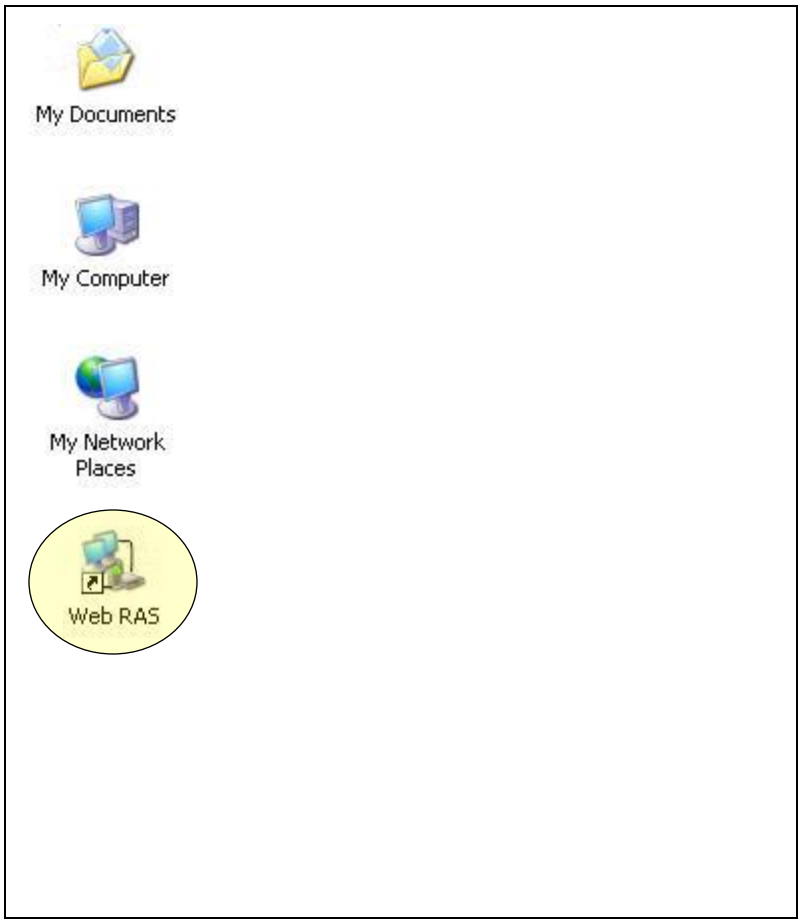
Screen Sample 5.11

Select For all users on the "Connection Availability" section (see Screen Sample 5.11) of the Network Connection Wizard. This option allows all users on this computer to have access to the RAS. Click the Next button.

Screen Sample 5.12

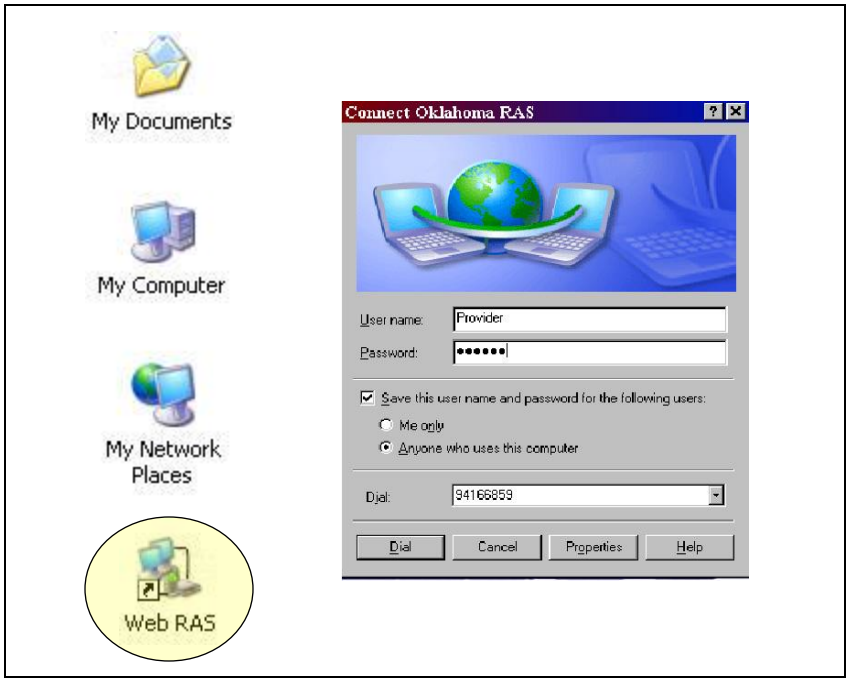
Finally, assign a name to use for the connection (see Screen Sample 5.12). After typing the new connection name in the specified box, click on the "Add a shortcut to my desktop" check box. This option will create an icon on your computer desktop. This enables you to click on the icon whenever you wish to log on to the RAS. After clicking on the Finish button, all the information needed to access the RAS is saved and stored on your computer.

ACCESSING THE RAS



Screen Sample 5.13

To access the RAS, double click on the shortcut icon found on the desktop (this icon was created when establishing the RAS Connection Setting through the Setup Wizard) (see Screen Sample 5.13). This launches the Connection Box prompt for the RAS.



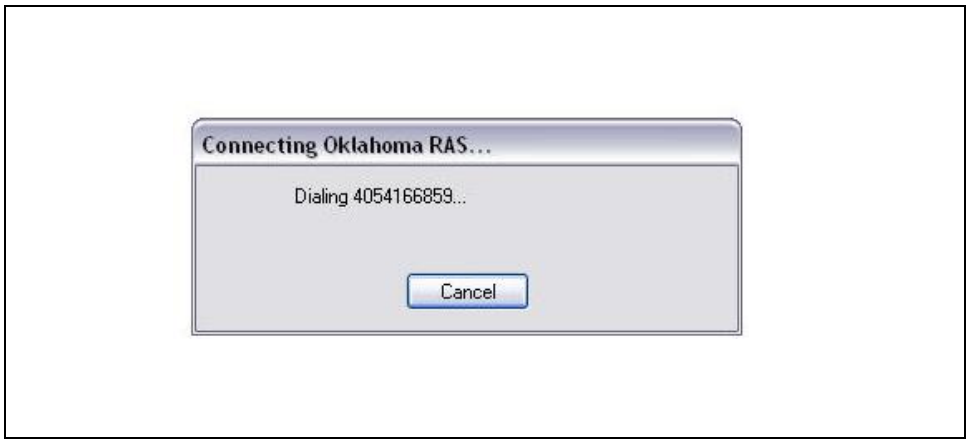
Screen Sample 5.14

In the Connection Box prompt (see Screen Sample 5.14), type in the user name and password. All providers accessing the RAS will use the same default user name and password:

Username: Provider
Password: eds123

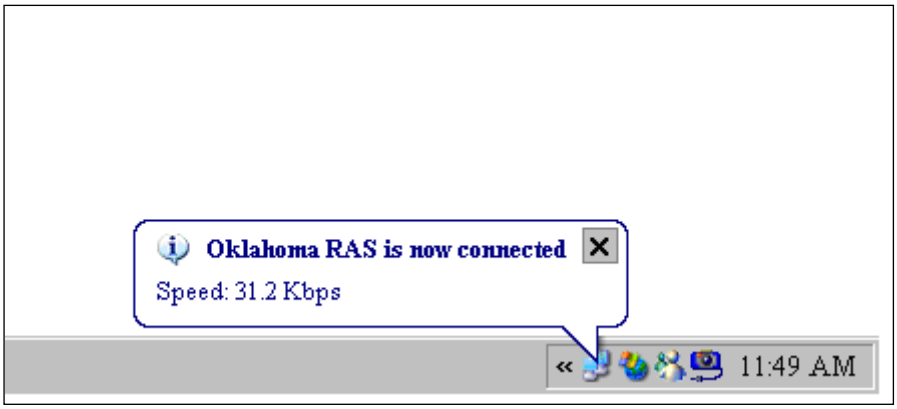
After typing the user name and password, check the dial-up number to ensure that your computer will dial the correct number. The RAS dial-up phone number is 405-416-6859

Once the dial-up number is validated, click on the Dial button. This will prompt the computer to attempt connection to the RAS (see Screen Sample 5.15).



Screen Sample 5.15

After connecting and username and password authentication is complete, you will see a prompt in the lower right corner of your desktop verifying the connection (see Screen Sample 5.16).



Screen Sample 5.16

After connecting to the RAS, open a Web browser and type https://192.168.100.163/Oklahoma/Security/logon.xhtml into the browser bar.

Chapter 6

Claim Completion

INTRODUCTION

The following information is intended to provide procedures for submitting claims to the OHCA. For information on what services are covered by the Oklahoma SoonerCare program, please access the agency rules. Rules can be found at www.okhca.org. There are three methods for submitting claims to the OHCA: paper, direct data entry (DDE) via Medicaid on the Web and through 837 batch transactions. Below is a paper-to-electronic conversion table for the different claim-submission types. Please refer to the EDI chapter of this manual for instructions on completing the HIPAA transaction types.

Paper	DDE	HIPAA Transactions
1500	Professional	837P
UB 04	Institutional	837I
ADA 2006	Dental	837D
Pharmacy Drug Claim Form	Pharmacy	NCPDP, version 5.1
Compound Prescription Drug Claim Form	Pharmacy	NCPDP, version 5.1

SECTION A: PAPER CLAIM RECOMMENDATIONS

Claim forms are prepared as follows:

1. Enter complete information with a typewriter, personal computer or ballpoint pen (blue or black ink). Do not use red ink.
2. Provide all required information for every claim line. Do not use ditto marks or the words “same as above.”
3. Verify the accuracy of all information before submitting the claim.
4. Follow the instructions for preparing paper claim forms in this chapter.
5. 1500, UB 04, Drug/Compound and ADA 2006 claim forms are scanned into the OKMMIS. Paper claim forms should be submitted on the original red forms to facilitate the scanning process. This applies to 1500 and UB 04 claim forms. If you submit a copy it must be legible.
6. Mail paper claims to the appropriate mailbox address listed in each claim section.
7. The attachments for a claim should be placed under the identified claim for processing. Do not place the attachment on top of the claim form or it will be associated to previously

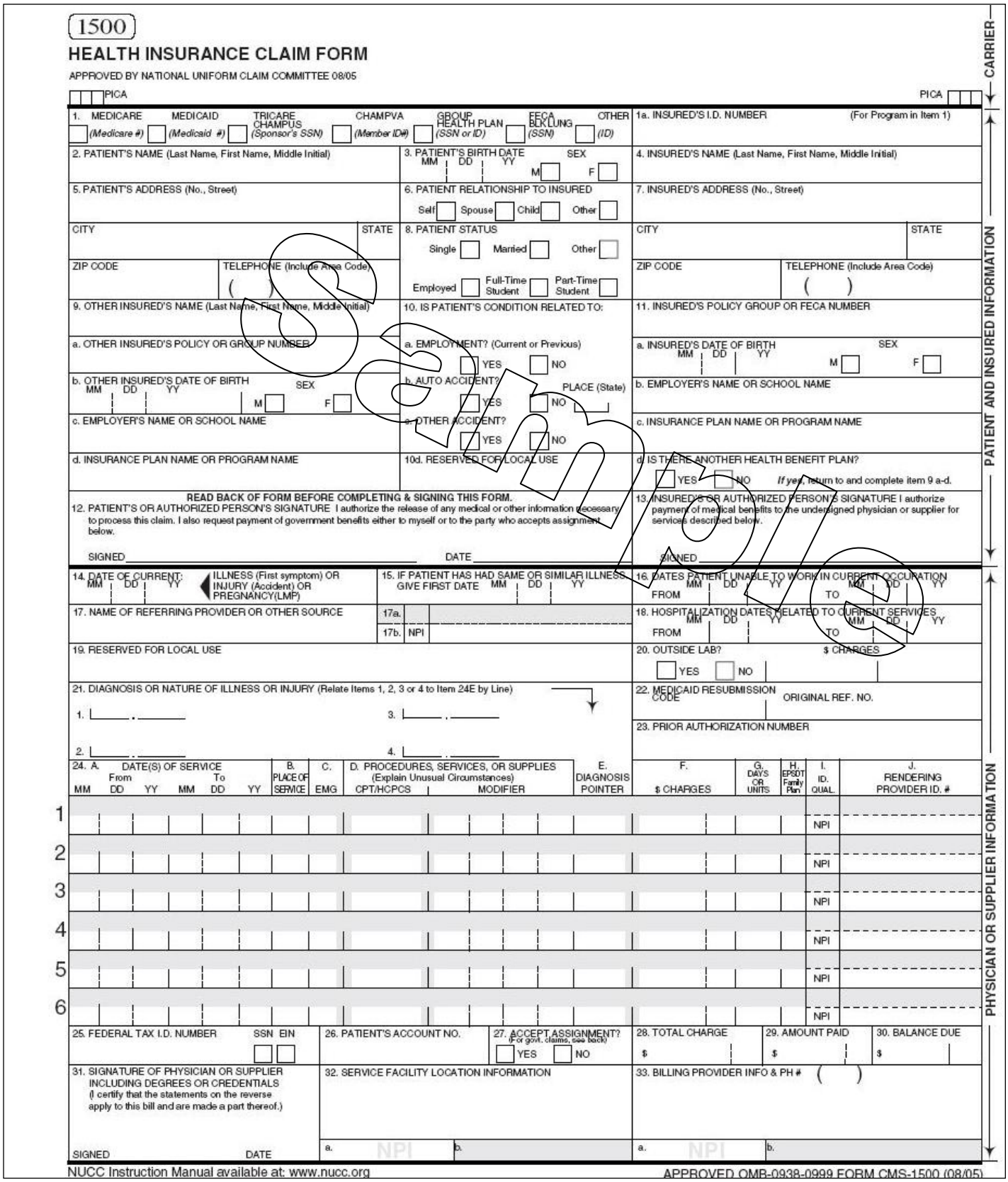
processed claim. If the attachment is stapled to the claim, place one staple in the upper left corner.

ORDERING PAPER CLAIM FORMS

UB-04, 1500, and ADA 2006 (dental) claim forms can be ordered from a standard form supply company. HP does not distribute supplies of these forms. Drug and Compound prescription claim forms can be downloaded from the OHCA Web site, ordered by contacting the OHCA Call Center or by writing a request to:

HP Form Request
P.O. Box 18650
Oklahoma City, OK 73154-0650

SECTION B: 1500, PROFESSIONAL, 837P



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FIELD DESCRIPTION FOR 1500 CLAIM FORM

The 1500 Health Insurance Claim Form (formerly known as the HCFA-1500 and CMS-1500), is the required claim form used by medical providers for professional services, unless otherwise specified. The provider must purchase these forms. This section explains how to complete the paper 1500 claim form.

The form locator chart below indicates which fields are *optional, required* or *required, if applicable*. Where necessary, directions applicable to specific provider types are noted. Please mail paper claims to the appropriate mailbox addresses below.

1500
HP Enterprise Services
P.O. Box 54740
Oklahoma City, OK 73154

Medicare Crossover (1500 form)
HP Enterprise Services
P.O. Box 18110
Oklahoma City, OK 73154

Waiver Services
HP Enterprise Services
P.O. Box 54016
Oklahoma City, OK 73154

HMO Co-Pay/Personal Care Service (individual, not agency)
HP Enterprise Services
P.O. Box 18500
Oklahoma City, OK 73154

Lab or DME
HP Enterprise Services
P.O. Box 18430
Oklahoma City, OK 73154

Form Locator	1500 Field Description/Explanation
1	Insurance Location Selection – Enter X for Medicaid. *Required.*
1a	Insured's ID Number – Enter the member's SoonerCare identification number. Must be nine digits. *Required.*
2	Patient's Name – (Last name, first name, middle initial) – Enter the member's last name, first name and middle initial. *Required.*
3	Patient's Birth Date – Enter the member's birth date in MMDDYY format. Sex – Enter an X in the appropriate box. *Optional.*

Form Locator	1500 Field Description/Explanation
4	Insured's Name – (Last name, first name, middle initial). *Optional.*
5	Patient's Address - (No., street), CITY, STATE, ZIP CODE, TELEPHONE (Include area code) – *Optional.*
6	Patient relationship to insured – *Optional.*
7	Insured's Address - (No., street), CITY, STATE, ZIP CODE, TELEPHONE (Include area code) – *Optional.*
8	Patient Status – Enter X in the appropriate box. *Optional.*
9	Other Insured's Name – *Optional.*
9a	Other Insured's Policy or Group Number – *Optional.*
9b	Other Insured's Date of Birth. Enter the date in MMDDYY format. – Optional. Sex – Enter X in the appropriate box. *Optional.*
9c	Employer's Name or School Name – *Optional.*
9d	Insurance Plan Name or Program Name – If other insurance is available, enter the commercial or private insurance plan name. *Required, if applicable.*
10	Is Patient's Condition Related to – Enter X in the appropriate box of each of the three categories. This information is needed to follow-up third party recovery actions. *Required, if applicable.*
10a	Employment? – (Current or previous) – Check "Yes" or "No" to indicate if the services being billed are employment related. *Required, if applicable.*
10b	Auto Accident? – Check "Yes" or "No" to indicate if the services being billed are related to an auto accident. Required, if applicable. Place (State) – Enter the two-character state code. *Required, if applicable.*
10c	Other Accident? – Check "Yes" or "No" to indicate if services being billed are related to an accident of another type. *Required, if applicable.*
10d	Reserved for Local Use – Enter the total dollar amount paid by a primary insurance carrier (for example, 45.00). You do not need to enter a dollar sign ($). Do not put amount paid by Medicare. If the primary insurance carrier did not issue payment, write the words, "*Carrier Denied*" in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims. *Required, if applicable.*

Form Locator	1500 Field Description/Explanation
11	Insured's Policy Group or FECA Number – If the member has more then one private or commercial insurance, follow directions for form locator 9 in this area. *Required, if applicable.*
11a	Insured's Date of Birth. - *Optional.*
11b	Employer's Name or School Name – *Optional.*
11c	Insurance Plan Name or Program Name – If other insurance is available, enter the commercial or private insurance plan name. *Required, if applicable.*
11d	Is There Another Health Benefit Plan – Enter X in the appropriate box. Provide additional third, or more private or commercial insurance information on a separate piece of paper using the directions found in form locator 9. *Required, if applicable.*
12	Patient's or Authorized Person's Signature. – *Optional.*
13	Insured's or Authorized Person's Signature – *Optional.*
14	Date of Current Injury, Illness, or Pregnancy – Enter the date in a MMDDYY format of the onset of the illness (day of first symptom) or injury (accident). OB claims must indicate the date the member was first seen for the pregnancy. Required, if applicable, or if form locator 10 has a box checked 'Yes'.
15	If Patient Has Had Same or Similar Illness, Give First Date – Enter date in MMDDYY format. *Optional.*
16	Date Patient Unable to Work in Current Occupation. – *Optional.*
17*	Name of Referring Physician or Other Source – Enter the name of the referring physician. *Required, if applicable.*
17a – 17b	Referring physician's ID number.
17a (shaded area)	ID Number of Referring Physician – (small box) Enter the two-character qualifier "1D" to indicate the referring provider's ID number is a SoonerCare ID number. *Optional*. (large box) Enter the 10-character referral number from the Referral Form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. Referral form submission with the claim is not required. *Required, if applicable.*

Form Locator	1500 Field Description/Explanation
17b (unshaded area)	NPI Number of Referring Physician – Enter the 10-digit National Provider Identifier (NPI) number from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. Referral form submission with the claim is not required. *Optional.*
18	Hospitalization Dates Related to Current Service – Enter the requested FROM and TO dates in MMDDYY format. *Required, if applicable*.
19	Reserved for Local Use – *Optional.*
20	Outside Lab– Enter X in the appropriate box. Optional $ CHARGE – Eight-digit numeric field. *Optional.*
21.1 to 21.4	Diagnosis Nature of Illness or Injury – Enter the diagnosis codes in order of importance: (1) primary; (2) secondary; (3) tertiary; (4) quaternary. These indicators will correspond to the appropriate procedures and be listed in box 24E as 1, 2, 3 or 4. *Required, if applicable*.
22	SoonerCare Resubmission Code, Original Ref No. – *Optional.*
23	Prior Authorization Number – The prior authorization (PA) number is not required as the information is systematically verified. *Optional.* The CLIA certification number is required to be put in this block when billing for laboratory services. *Required, if applicable.*

Form Locator	1500 Field Description/Explanation
24 a – j (shaded area)	*24a* - Enter NDC qualifier "N4" followed by the 11-digit NDC number in 24a. For example: N499999999999. The NDC should be placed in shaded area above the corresponding HCPCS codes (refer to 24d unshaded area for additional instructions). Do not enter any spaces or dashes. *24b and 24c* – Do not enter any information in these fields. *24d* - Enter the unit of measure of "UN" for unit, "F2" for international unit, "ML" for milliliter or "GR" for gram followed by the metric decimal quantity. For example: UN103.50. Do not use spaces or dashes and do not include a description or any information beyond what is indicated above. *24e through 24i* – Do not enter any information in these fields. *24j* - Enter the nine-digit, one alpha character SoonerCare legacy number in 24j. For example: 100200300A (needs to be fictitious # such as 999999999A) *Required, if applicable.*
24 (unshaded area)	Detail service lines should be listed in the unshaded areas of 24a - 24j. A maximum of six service lines are allowed per claim.
24a (unshaded area)	Date of Service – Enter FROM and TO dates in MMDDYY format for the billing period for each service rendered. Six detail lines are allowed per form. *Required.*

<table>
<tr><th>Form Locator</th><th>1500 Field Description/Explanation</th></tr>
<tr><td>24b (unshaded area)</td><td>Place of service – Enter the place of service code for the place services were rendered. Required.
Place of Service Codes
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>11</td><td>Office</td></tr>
<tr><td>12</td><td>Home</td></tr>
<tr><td>20</td><td>Urgent care facility</td></tr>
<tr><td>21</td><td>Inpatient hospital</td></tr>
<tr><td>22</td><td>Outpatient hospital</td></tr>
<tr><td>23</td><td>Emergency room</td></tr>
<tr><td>24</td><td>Ambulatory surgical center (ASC)</td></tr>
<tr><td>25</td><td>Birthing center</td></tr>
<tr><td>26</td><td>Military treatment facility</td></tr>
<tr><td>31</td><td>Skilled nursing facility (SNF)</td></tr>
<tr><td>32</td><td>Nursing facility (NF)</td></tr>
<tr><td>33</td><td>Custodial care facility</td></tr>
<tr><td>34</td><td>Hospice</td></tr>
<tr><td>41</td><td>Ambulance – land</td></tr>
<tr><td>42</td><td>Ambulance – air or water</td></tr>
<tr><td>51</td><td>Inpatient psychiatric facility</td></tr>
<tr><td>52</td><td>Psychiatric facility – partial hospitalization</td></tr>
<tr><td>53</td><td>Community mental health center</td></tr>
<tr><td>54</td><td>Intermediate care facility for the mentally retarded (ICF/MR)</td></tr>
<tr><td>55</td><td>Residential substance abuse treatment facility</td></tr>
<tr><td>56</td><td>Psychiatric residential treatment center</td></tr>
<tr><td>61</td><td>Comprehensive inpatient rehabilitation facility</td></tr>
<tr><td>62</td><td>Comprehensive outpatient rehabilitation facility</td></tr>
<tr><td>65</td><td>End-stage renal disease treatment facility</td></tr>
<tr><td>71</td><td>State or local public health clinic</td></tr>
<tr><td>72</td><td>Rural health clinic (RHC)</td></tr>
<tr><td>81</td><td>Independent laboratory</td></tr>
<tr><td>99</td><td>Other unlisted facility</td></tr>
</table></td></tr>
<tr><td>24c (unshaded area)</td><td>EMG - Emergency indicator. If services are related to an emergency, enter ‘Y’. If not, enter ‘N’. Optional.</td></tr>
</table>

<table>
<tr><th>Form Locator</th><th>1500 Field Description/Explanation</th></tr>
<tr><td>24d (unshaded area)</td><td>Procedures, Services, or Supplies
CPT/HCPCS – Enter the appropriate procedure code for the service rendered. Only one procedure code is billed on each claim form detail line. If your procedure code requires an NDC, enter the appropriate HCPCS code and refer to 24 a-j shaded area for additional instructions. Required.
Modifier – Enter the appropriate modifier, as applicable. Up to four modifiers can be entered for each detail line. Required, if applicable.</td></tr>
<tr><td>24e (unshaded area)</td><td>Diagnosis Pointer – Enter the numeric codes (1, 2, 3 or 4), in order of importance, which correspond to the diagnosis code listed in form locator 21. A minimum of one and maximum of four diagnosis code pointers can be entered on each line. Do not enter the full diagnosis code. Required, if applicable.</td></tr>
<tr><td>24f (unshaded area)</td><td>$ Charges – Enter the charges for each line item on the claim form. Required.</td></tr>
<tr><td>24g (unshaded area)</td><td>Days or Units – Enter the appropriate number of units of services provided for the procedure code. Whole and decimal numbers are acceptable. Required.</td></tr>
<tr><td>24h (unshaded area)</td><td>EPSDT Family Plan –If the services being provided are related to an EPSDT visit, enter ‘Y’. If not, enter ‘N’ or leave blank. If a ‘Y’ is entered, the two-digit EPSDT code must be entered in the shaded area above the box. Required, if applicable.</td></tr>
<tr><td>24h (shaded area)</td><td>EPSDT Family Plan – If a ‘Y’ is entered in the unshaded area of box 24h, enter the two-digit referral type in this box. Appropriate codes are:
<table>
<tr><td>NU – Not Available</td><td>AV – Available, Not Used</td></tr>
<tr><td>ST – New Services Requested</td><td>S2 – Under Treatment</td></tr>
</table>
</td></tr>
<tr><td>24i – 24j</td><td>When entering the rendering provider’s ID number, only use the shaded areas of 24i – 24j. When entering the Providers NPI number, use the unshaded area of 24j.</td></tr>
<tr><td>24i (shaded area)</td><td>ID Qual. – Enter the two-character qualifier, indicating the type of provider number being used for the rendering provider. Enter ‘1D’ to indicate the type of provider number used is for Oklahoma SoonerCare. Optional.</td></tr>
</table>

Form Locator	1500 Field Description/Explanation
24j (shaded area)	Rendering Provider ID # - Enter the 10-character Oklahoma SoonerCare provider number of the rendering provider. This field can be left blank if billing and rendering numbers, including location code, are identical. *Required, if applicable.*
24i (unshaded area)	ID Qual – This area is already populated with 'NPI,' indicating that the provider number listed for the rendering provider is the NPI.
24j (unshaded area)	Rendering Provider ID # - Enter the rendering provider's 10-digit NPI. *Optional.*
25	Federal Tax ID Number – *Optional.*
26	Patient's Account Number – Enter the internal patient tracking number. If the account number is supplied, it will appear on the remittance advice. *Optional.*
27	Accept Assignment? – Oklahoma SoonerCare only accepts assigned claims. *Required.*
28	Total Charges– Enter the total of column 24f charges. Each page must have a total. Claims cannot be continued to two or more pages. *Required.*
29	Amount Paid – Enter the amount paid by the member. *Required, if applicable.*
30	Balance Due– Field 28, TOTAL CHARGE BALANCE DUE. *Required.*
31	Signature of Physician or Supplier– The name of the authorized person, someone designated by the agency or organization and the date the claim was created. A signature stamp is acceptable; however, the statement "Signature on File" is not allowed. *Required.* DATE – Enter the date the claim was filed. Be sure not to write any portion of the date outside of the designated box. The date billed must be on or after the date(s) of service. *Required.*
32	Name and Address of Facility Where Services Were Rendered - Enter the provider's name and address if other than home office. *Optional.*
32a	Enter the 10-digit NPI number of the facility where the services were rendered. *Optional.*
32b	Enter the two-character qualifier "1D" and 10-character Oklahoma SoonerCare provider ID number of the facility where the services were rendered. No spaces or dashes should be used. *Optional.*

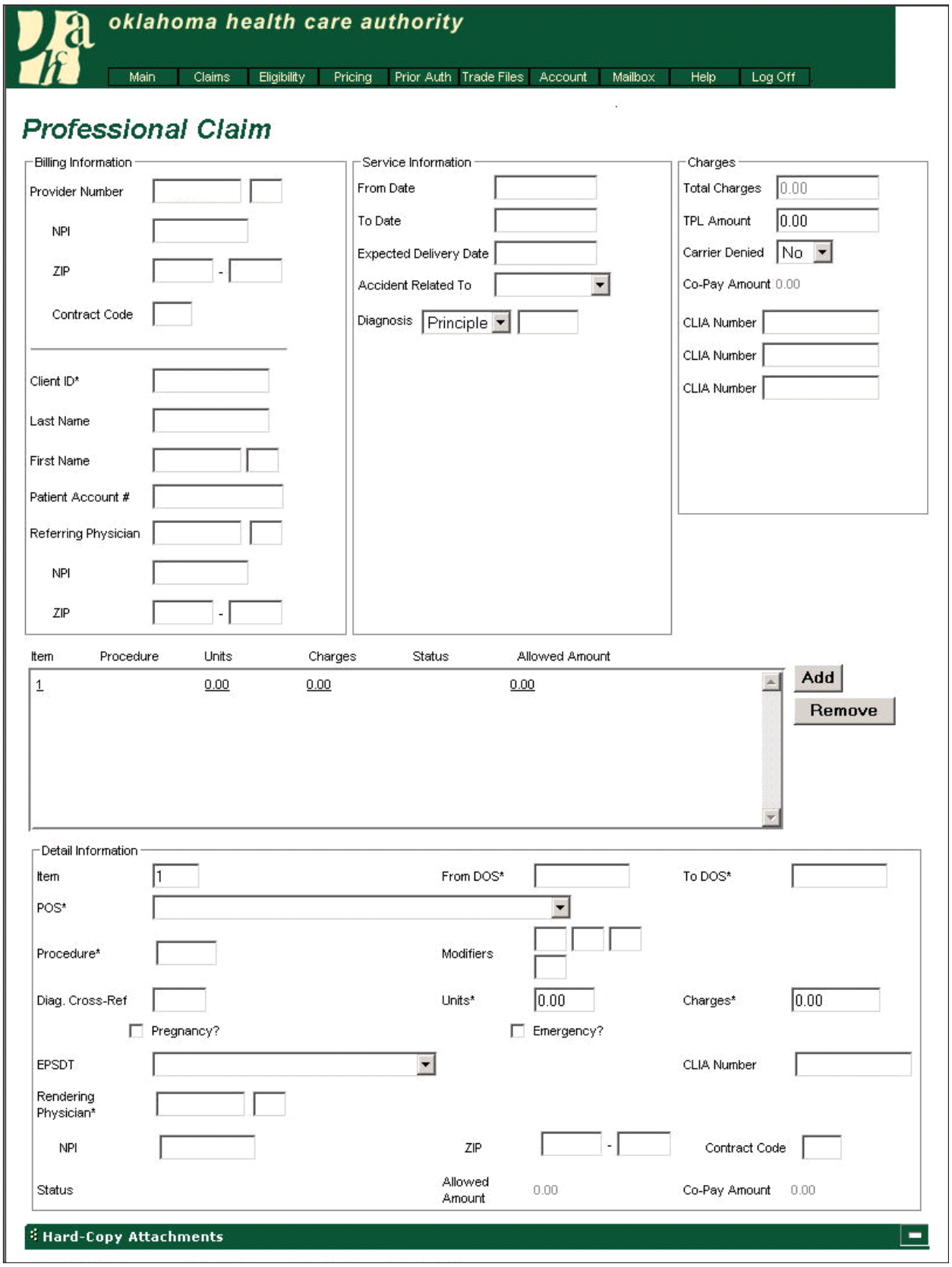
Form Locator	1500 Field Description/Explanation
33	PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE # - Enter the name, address, zip code and telephone number of provider requesting payment for services listed on claim form. If the provider furnished the services as part of a group practice organization, enter the name, address, zip code and telephone number of the group practice organization. *Required.*
33a	Enter the 10-digit NPI number of the physician or group. *Optional.*
33b	Enter the 10-character Oklahoma SoonerCare provider ID number of the billing provider. No spaces or dashes should be used. *Required. (Use of the 1D Medicaid qualifier is optional)*

DIRECT DATA ENTRY (DDE) CLAIM SUBMISSION (PROFESSIONAL)

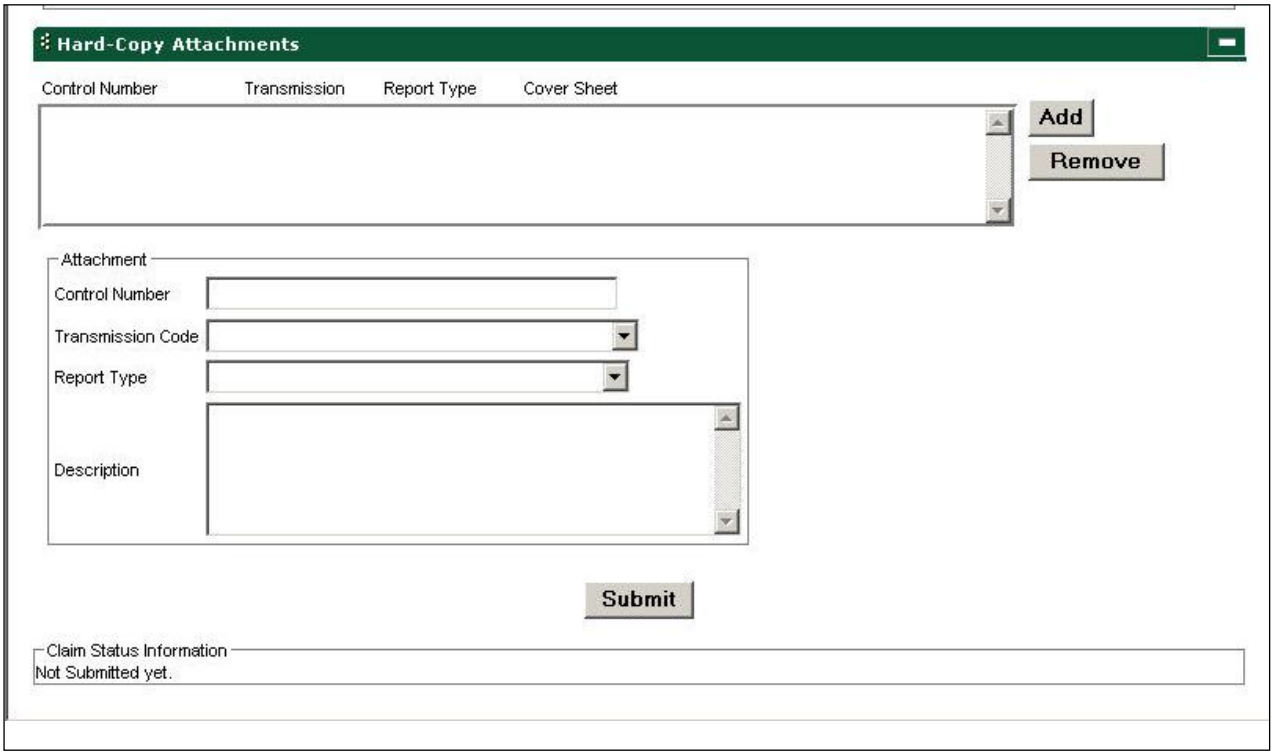
Use the Professional claim form example and directions below as guides when submitting claims through DDE on Medicaid on the Web. To open the form, choose the 'Submit Professional' (see Screen Sample 6.1) claim option from the Claims.

NOTE: *Medicare denials and crossover claims cannot be billed through the Secure Site using DDE as they are required to be billed on paper*.

Screen Sample 6.1



Screen Sample 6.2



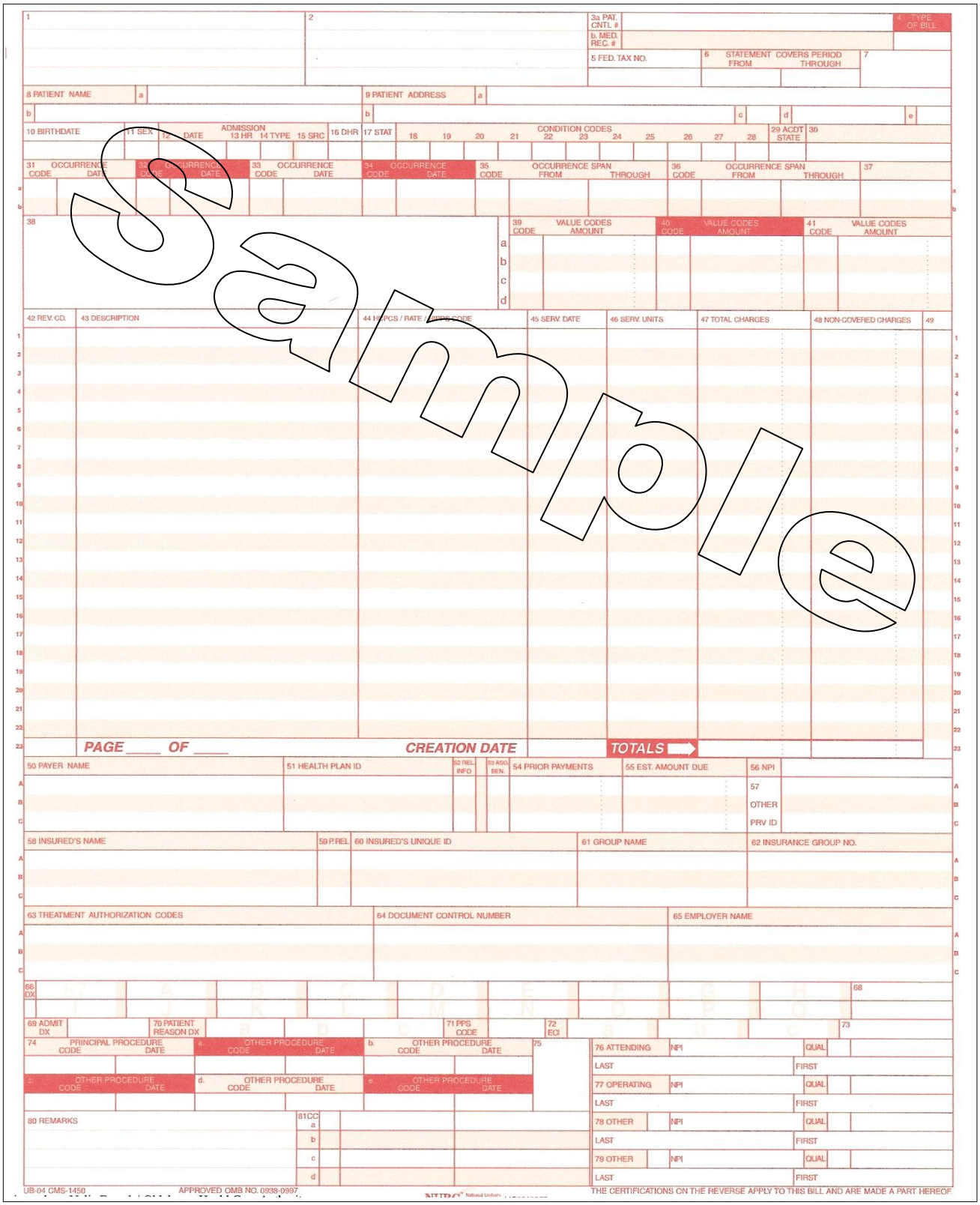
Screen Sample 6.2 continued

DDE Professional Claim Submission Instructions
Billing Information
Provider ID - Provider Number - Your Provider ID should appear in the first box. Verify it is correct. If it is not, you may need to log out and access the correct provider. *Required.*
Client ID - Enter the member's Oklahoma SoonerCare ID number in the Client ID field. (The patient's last and first name will auto populate when the member's ID number is in the system.) *Required.*
Patient Account # - The Patient account number will be captured and appear on the remittance advice, if entered into this field. *Optional.*
Referring physician - Enter the 10-character referral number from the referral form, if the member is enrolled in the SoonerCare Choice program. *Required, if applicable.* See 1500 form locator 17A.
Service Information
From Date - Enter the from date of service into the From Date field. *Required.*
To Date - Enter the to date of service into the To Date field. *Required.*
Expected Delivery Date - Enter the expected delivery date into the Expected Delivery Date field. *Required, if applicable.*

DDE Professional Claim Submission Instructions
Accident Related To - If claim is related to an accident, select accident type in the Accident Related To field. *Required, if applicable.*
Diagnosis - Select appropriate diagnosis type in the Diagnosis field by choosing from the drop-down menu. Enter the diagnosis code(s). DO NOT ENTER DECIMALS. *Required.* See 1500 form locator 24 for more information.
Charges
Total Charges - Total Charges field is automatically populated.
TPL Amount - Enter the amount paid by any other insurance. If no other insurance is involved or has paid on this claim, leave this field at 0.00. *Required, if applicable.*
Carrier Denied – If there is other insurance involved and the primary carrier denied the charges, or allowed coverage but did not make a payment (for example: applied to deductible), select 'Yes.' If the primary carrier made a payment or if there is no other insurance involved, select 'No.' *Required, if applicable.*
Detail Information
From DOS - Enter the from date of service in the From DOS field. This will auto-populate from the line detail. *Required.*
To DOS - Enter the to date of service in the To DOS field. This will auto-populate from the line detail. *Required.*
POS - Select the place of service code using the drop-down window. *Required.*
Procedure - Enter the CPT or HCPCS procedure code in the Procedure field. See 1500 form locator 24d for more information. *Required.*
Modifier - Enter modifier code(s) in the Modifier field(s). *Required, if applicable.*
Diag. Cross-Ref - Enter the numeric codes (1, 2, 3 or 4), in order of importance, which correspond to the diagnosis code listed in form locator 21. A minimum of one and maximum of four diagnosis code pointers can be entered on each line. Do not enter the full diagnosis code and do not use commas. *Required, if applicable.*
Units - Enter number of units billed in the Units field. *Required.*
Charges - Enter the total dollar amount of charges for that specific detail in the Charges field. This action will auto-populate the Total Charges field. *Required.*
Pregnancy? - If claim is related to a pregnancy, check the Pregnancy? box. *Required, if applicable.*
Emergency? - If claim is related to an emergency, check the Emergency? box. *Required, if applicable.*

DDE Professional Claim Submission Instructions
EPSDT - If claim is related to an EPSDT service, select the appropriate referral type from the drop-down list. If nothing is entered, this field will default to 'No'. *Required, if applicable.*
Rendering Physician – If different from the billing provider number, enter the rendering physician's SoonerCare ID number and location code in the Rendering Physician field. This is the rendering provider and is not necessarily a physician. *Required, if applicable.*
If additional items are to be billed on this submission, click the Add button next to the line item window and repeat process. Click the Remove button to remove a line entry.
Hard Copy Attachments
If a hard-copy attachment is to be added, use the Hard-Copy Attachments arrow at the end of the bar. Enter an attachment control number as assigned by the provider in the Attachment Control Number field. The transmission code is entered in the Transmission Code field by clicking on the down arrow, highlighting the appropriate code and clicking on it. Report type code can be entered into the Report Type field by clicking on the down arrow to make the selection. Free form text can be entered into the Description field. Complete form HCA-13 "Paper Attachment to Electronic Claims," and mail or fax the attachment control number form. See Section F in this chapter for instructions on completing form HCA-13. Attachment control numbers cannot be made up of special characters or include spaces. *Required, if applicable.*
Submit - When finished, click on the Submit button. *Required.*

SECTION C: UB 04, INSTITUTIONAL, 837I



FIELD DESCRIPTIONS FOR THE UB-04 CLAIM FORM

The UB-04 Universal Billing Claim Form, is used to bill for facility services covered under the OHCA's Medical Program, unless otherwise specified in this chapter. The provider must purchase these forms. This section explains how to complete the paper UB-04 claim form. The form locator chart indicates which fields are optional; required; required, if applicable or not captured.

Providers should use the UB-04 billing manual instructions unless otherwise specified. The UB-04 manual can be obtained by contacting the National Uniform Billing Committee at www.nubc.org. Please mail paper claims to the appropriate mailbox address below:

UB-04 (Hospital or Home Health)
HP Enterprise Services
P.O. Box 18430
Oklahoma City, OK 73154

HMO Co-pay
HP Enterprise Services
P.O. Box 18500
Oklahoma City, OK 73154

Long-term-care Nursing Facility
HP Enterprise Services
P.O. Box 54200
Oklahoma City, OK 73154

Medicare Crossovers (UB-04)
HP Enterprise Services
P.O. Box 18110
Oklahoma City, OK 73154

Form Locator	UB-04 Field Description/Explanation
1	Please Remit Payment To – Provider name, address and telephone number - *Required.*
2	Unlabeled field – *Not captured.*
3a	PATIENT CNTL #. – Enter the internal patient account number. This number will appear on the remittance advice. Up to 24 characters. *Required.*
3b	MED REC # - This is a HIPAA required number that must be no more than 24 characters. This number is assigned by the provider to identify the medical health records of the patient. *Required.*

Form Locator	UB-04 Field Description/Explanation
4	TYPE OF BILL – Enter the code indicating the specific type of bill. This four-digit code requires one digit from each of the following categories, including a leading zero. First - leading 0; Second – Type of Facility; Third – Bill Classification; Forth - Frequency Please consult the National UB-04 Uniform Billing Manual for type of bill codes. *Required.*
5	FED. TAX NO. – *Not captured.*
6	STATEMENT COVERS PERIOD – Enter the beginning and ending service dates included in this bill. For all services rendered on a single day, use both the FROM and THROUGH dates. Enter in the MMDDYY format, such as 011205. Total days must equal days shown indicated in form locator 39-41 and total units located in form locator 46 with the exception of discharge day. *Required.*
7	Unlabeled field - *Not captured.*
8 a-b	PATIENT NAME – a - Not captured. b – Enter member's last name, first name, and middle initial. *Required.*
9 a-e	PATIENT ADDRESS - *Not captured.*
10	BIRTHDATE - *Not captured.*
11	SEX - *Not captured.*
12	ADMISSION DATE – Enter the date the patient was admitted for inpatient care in a MMDDYY format. *Required.*
13	ADMISSION HOUR – Enter the two-digit code for the hour during which the patient was admitted for inpatient care using the 24 hour format (for example: 7:00 PM = 19). *Required.*
14	ADMISSION TYPE – Enter the code indicating the priority of this admission. Type must be numeric. See NUBC's UB-04 manual for details. *Required.*
15	SOURCE OF ADMISSION– Enter code indicating how the patient was admitted. See NUBC's UB-04 manual for more detail. *Required.*
16	DHR –*Not captured.*

Form Locator	UB-04 Field Description/Explanation
17	STAT – Enter the code indicating the member status as of the ending service date of the period covered on this bill. This is a two-digit 01-99 code. Codes for patient status are detailed in the National UB-04 Uniform Billing Manual and indicate if the member is still a patient, deceased, discharged and other statuses. See NUBC's UB-04 manual for more detail. *Required.*
18 - 28	CONDITION CODES – Enter appropriate code. See NUBC's UB-04 manual for more detail. *Optional.*
29	*ACDT STATE - Not captured.*
30	Referring Provider ID Number – Enter the 10-character referral number from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma programs. (for example: 123456789A). Referral form submission with the claim is not required. *Required, if applicable.*
31-34 a & b	OCCURRENCE CODE and DATE – Enter the applicable code and associated date to identify significant events related to this bill that may affect processing. Dates are entered in a MMDDYY format. A maximum of eight codes and associated dates can be entered. See NUBC's UB-04 manual for more detail. *Required, if applicable.*
35-36 a – b	OCCURRENCE SPAN CODE, FROM/THROUGH – Enter the code and associated dates for significant events related to this bill. Each Occurrence Span Code must be accompanied by the span from and through date. *Required, if applicable.*
37b-c	Unlabeled field – *Not captured.*
38	Unlabeled field – *Not captured.*
39a – 41d	VALUE CODES –Enter code and amounts as applicable. Value Code 80 specifies the number of covered days. Days need to be listed in whole numbers, no decimals. *Required, if applicable.*
42 Lines 1-22	REVENUE CODES – Enter the applicable revenue code that identifies the specific accommodation, ancillary service, or billing calculation. The use of revenue code 001 is not required to indicate total billed; if programmed please put 001 in form locator 42 line 23. *Required.*

Form Locator	UB-04 Field Description/Explanation
43 Lines 1-22	DESCRIPTION – Using no spaces or dashes, enter NDC qualifier "N4;" the 11-digit NDC number; the unit of measure of "UN" for unit, "F2" for international unit, "ML" for milliliter or "GR" for gram; and the metric decimal quantity. For example: N499999999999UN999.99. Corresponding HCPCS code should be placed on the same line as NDC. *Required*, if applicable.
44 Lines 1-22	HCPCS/RATES – Enter the Health Care Procedure Coding System (HCPCS) code applicable to the service provided. Only one service code per line is permitted. *Required for DME, outpatient, X-ray, lab, rural health, EKG, EEG, and pharmacy.*
45 Lines 1-22	SERVICE DATE – The date the indicated outpatient service was provided on a series bill. *Required for all services except inpatient and long term care.*
46 Line 1-22	UNITS OF SERVICE – Enter the number of units corresponding to the revenue code and/or HCPCS code billed. *Required.*
47 Lines 1-22	TOTAL CHARGES – Enter the total charges pertaining to the related revenue code detail line. On the detail line that has the revenue code 001, add all of the charge details together and enter the sum of all charges billed in form locater 47. *Required.*
48	NON-COVERED CHARGES – *Not captured.*
49	Unlabeled Field – *Not captured.*
42 Line 23	Unlabeled. Enter the revenue code 001. *Optional*
43 Line 23	Page ___ of ____. The OHCA does not accept multiple-page claims. *Not used.*
45 Line 23	CREATION DATE - Enter the date billed. *Required.*
47 Line 23	TOTAL - Enter the total charges adding lines 1-22 together. *Required.*
48 Line 23	Unlabeled: Total non-covered charges from lines 1-22. *Not captured.*
50A-55C	For form locators 50a-55c –Enter the appropriate order of insurance coverage A, Primary; B, Secondary; and C, Tertiary. (for example: A, Medicare; B, Medicare Supplement; and C, SoonerCare). If the member only has SoonerCare coverage, it should be listed in A. *Required.*
51A – 51C	HEALTH PLAN ID - *Not captured.*
52A-C	REL INFO -*Not captured.*

Form Locator	UB-04 Field Description/Explanation
53a – 53c	ASG. BEN. -*Not captured.*
54A – 54C	PRIOR PAYMENTS - Enter the amount paid by the insurance carrier identified in form locators 50a-b, as applicable. *Required, if TPL applies.* *When a TPL carrier makes payment on a claim, the Explanation of Benefits (EOB) is not required. The Explanation of Benefits (EOB) is always required if the TPL carrier denies the claim.*
55a – 55c	EST. AMOUNT DUE – The amount estimated by the provider to be due from the indicated payer. (estimated responsibility less prior payments). *Used for HMO Co-pays only.*
56	NPI –Enter the NPI of the billing provider. *Optional.*
57 a-c	Enter the 10-character SoonerCare provider ID for the billing provider in the corresponding line a – c from form locator 50 that indicates SoonerCare or Medicaid. *Required.*
58A – 58C	INSURED'S NAME – Enter insured's last name, first name, and middle initial. *Not captured.*
59A – 59C	P. REL – Patient's relationship to insured. *Not captured.*
60A – 60C	INSURED'S UNIQUIE ID. – Enter the member's identification number for the respective payers entered in form locator 50 a-c. The member's nine-digit SoonerCare identification number is required and should be listed in the same order as form locator 50 a-c. Other carriers are optional. *Required.*
61A – 61C	GROUP NAME – *Not captured.*
62A – 62C	INSURANCE GROUP NO. – *Not captured.*
63A – 63C	TREATMENT AUTHORIZATION CODES – *Not captured.*
64A – 64C	DOCUMENT CONTROL NUMBER– *Not captured.*
65A – 65C	EMPLOYER NAME – *Not captured.*
66	DX – *Not captured.*
67	PRIN. DIAG. CD. – Enter the diagnosis code describing the principal diagnosis. *Required.*

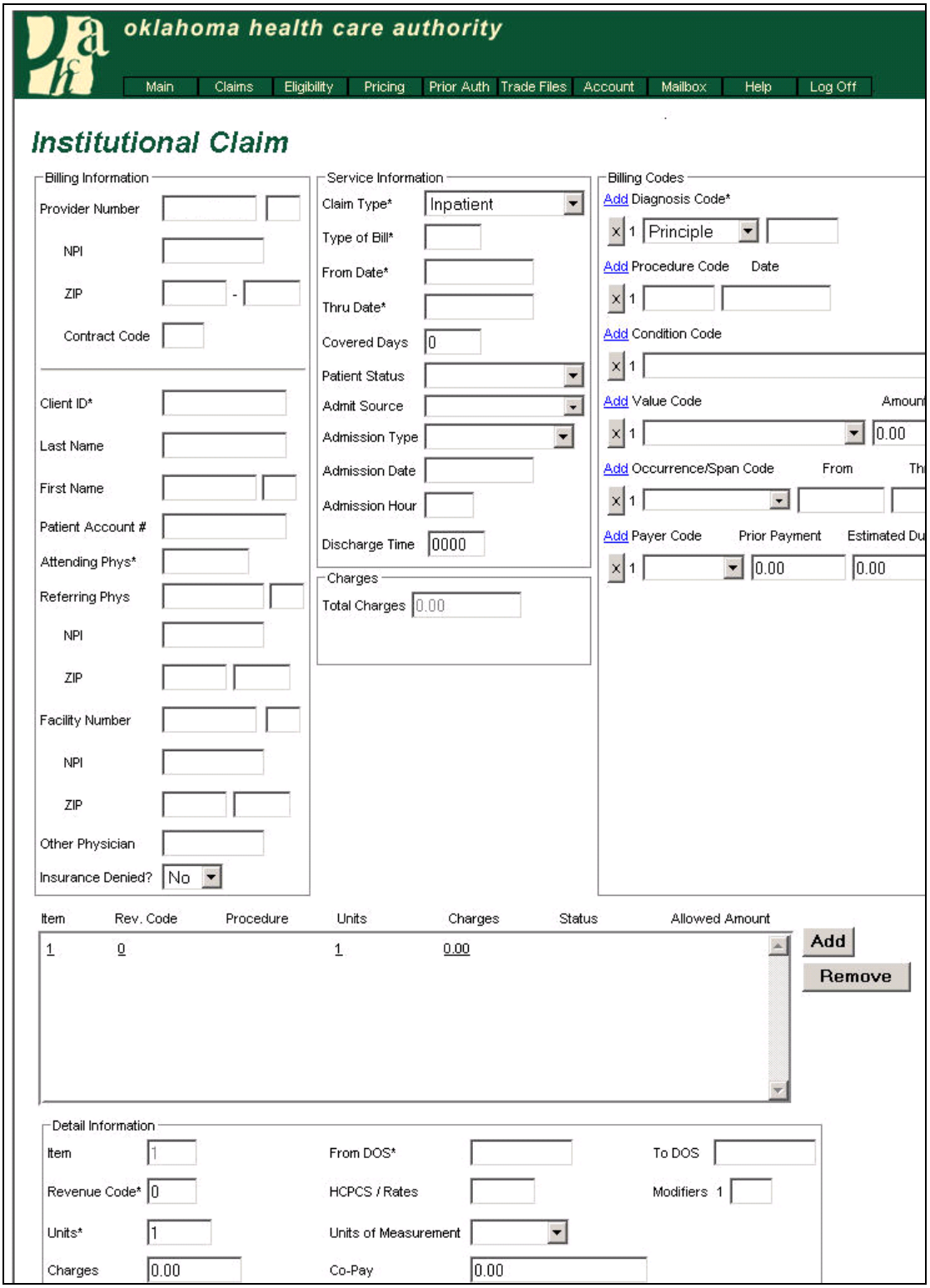
Form Locator	UB-04 Field Description/Explanation
67 A-Q	OTHER DIAG. CODES – Enter the diagnosis codes corresponding to additional conditions that exist at the time of admission or that develop subsequently and have an effect on the treatment received or the length of stay. *Required, if applicable.*
68	Unlabeled field - *Not captured*
69	ADM. DIAG. CD – Enter the diagnosis code provided at the time of admission as stated by the physician. *Required.*
70	Not captured.
71	Not captured.
72 a-c	ECI – "a" is the only field captured. *Optional*. *"b and c" are not captured*.
73	Not captured.
74	PRINCIPAL PROCEDURE CODE/DATE – Enter the ICD-9-CM procedure code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed. Do not use HCPCS or CPT codes. *Required for surgery.*
74 a-e	OTHER PROCEDURE CODE/DATE – Enter the ICD-9-CM procedure codes identifying all significant procedures other than the principal procedure and the dates identified by codes on which the procedures were performed. Report the most important for the encounter and specifically any therapeutic procedures closely related to the principal diagnosis. Do not use HCPCS or CPT codes. *Optional.*
75	*Not captured.*
76	ATTENDING PHYS. ID : NPI – *Required, if applicable.*
77A	OTHER PHY. ID: NPI – *Required, if applicable.*
78-79	*Not captured.*

DIRECT DATA ENTRY (DDE) CLAIM SUBMISSION-INSTITUTIONAL

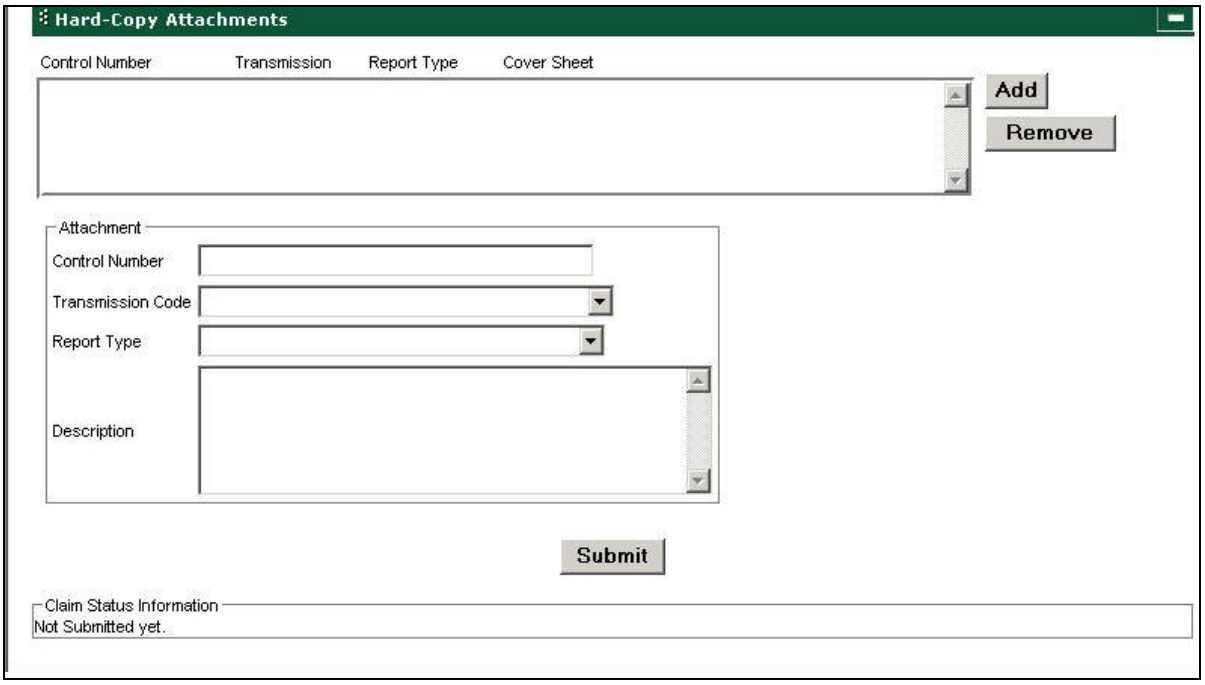
Use the Institutional claim form example and the directions below as guides when submitting a claim through DDE on Medicaid on the Web. Required fields are indicated. To access this form, choose the 'Submit Institutional' claim option (see Screen Sample 6.3) from the Claims button drop-down menu. Fields with an asterisk (*) are always required. Other fields may be required under certain circumstances.

Screen Sample 6.3

Detailed Instructions on specific OHCA requirements on acceptable codes are located in the corresponding UB-04 form (Screen Sample 6.4) locator information. Choose the option for 'Institutional' to obtain the fields.



Screen Sample 6.4



Screen Sample 6.4 continued

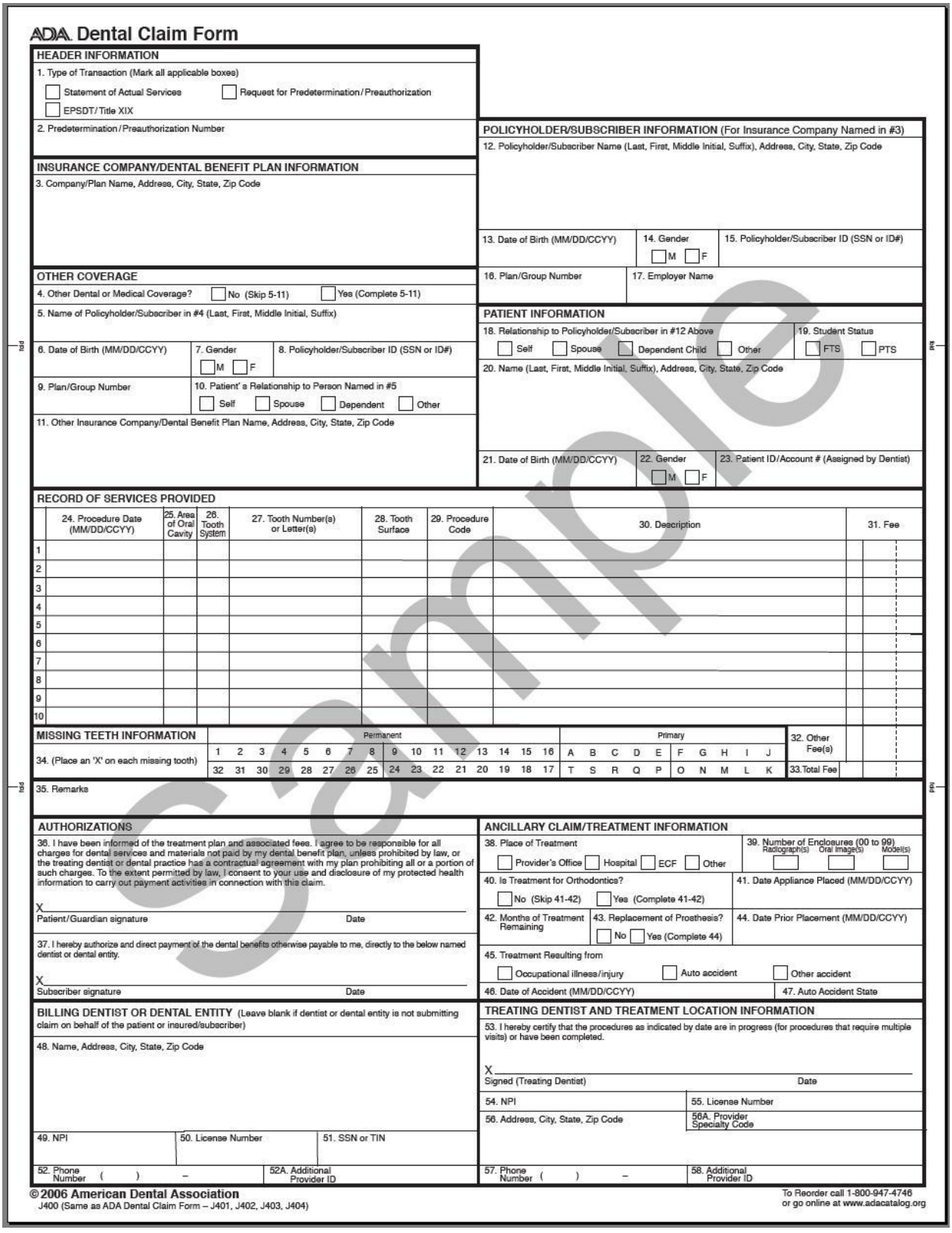
DDE Institutional Claim Submission Instructions
Billing Information
Provider Number - Your Provider ID should appear in the first box. Confirm it is correct. If it is not, you need to log out and access the correct provider. *Required.*
Client ID - Enter the member's Oklahoma SoonerCare ID number in the Client ID field. If the member ID entered is found in the system, the patient's last name and first name will auto populate. *Required.*
Patient Account # - Patient account number will be captured if entered into the Patient Account # field. *Optional.*
Attending Physician - Enter the seven-digit Oklahoma Prescriber ID number of the attending physician. Do not use the UPIN. *Required.*
Referring Physician – Enter the 10-character referral number from the Referral Form if the member is enrolled in the SoonerCare Choice program. *Required, if applicable.* See UB-04 form locator 83B for more information.
Facility Number – Enter the 10-character Oklahoma SoonerCare provider ID number of the facility where the services were performed, if the location is different than the billing provider number.
Other Physician - Enter other physician number in the Other Physician field. *Required, if applicable.* See UB-04 form locator 83A for more information.

DDE Institutional Claim Submission Instructions
Insurance Denied – If there is other insurance involved and the primary carrier denied the charges or allowed coverage but did not make a payment (i.e. applied to deductible), select 'Yes'. If the primary carrier made a payment or if there is no other insurance involved, select 'No'. *Required, if applicable.*
Service Information
Claim Type – Using the drop-down box, select the appropriate claim type.
Type of Bill - enter the three-digit bill code number in the Type of Bill field. First digit identifies Type of Facility. Second digit identifies Bill Classification. Third digit identifies Frequency. All positions must be fully coded. Please consult the National UB-04 Uniform Billing Manual for bill code types. *Required.*
From Date - Enter the from date of service into the From Date field. *Required.*
Thru Date - Enter the to date of service into the Thru Date field. *Required.*
Covered Days - Enter the number of eligible days in the Covered Days field. Required for inpatient and nursing home facilities. See UB-04 form locator 7 for more information.
Patient Status –Using the drop-down box, select the appropriate status in the Patient Status field. *Required.*
Admission Type - Using the drop-down box; select the type of admission in the Admission Type field. *Required, if applicable.*
Admission Date - Enter date of admission in the Admission Date field. *Required, if applicable.*
Admission Hour - Enter time of admission using 24-hour format (for example: 7:00 PM = 19) in the Admission Hour field. See UB-04 form locator 17 for more information. *Required, if applicable.*
Discharge Time - Enter time of discharge using 24-hour format (for example: 7:00 PM = 19) in the Discharge Time field. *Required, if applicable.*
Total Charges - The Total Charges field is automatically populated.
Billing Codes
Diagnosis - Select appropriate diagnosis type in the Diagnosis field by clicking on the drop-down arrow, highlighting the appropriate type and clicking on it. Then enter the diagnosis code(s). Admission and Primary diagnosis are required for inpatient and nursing home services. See UB-04 Form Locators 67-75 for more information.

DDE Institutional Claim Submission Instructions
Procedure Code and Date - Enter the appropriate ICD-9-CM procedure code and date in Procedure Code field. Do not use HCPCS or CPT codes. Enter date in the Date field. See UB-04 form locators 80-81 for more information.
Condition Code – Choose the appropriate Condition Code using the drop-down menu. *Optional.*
Value Code – Using the drop-down menu, choose the appropriate value code affecting this claim in the Value Code field and enter the dollar amount with cents. (for example: Correct: 45.00; Incorrect: $45) *Optional.*
Occurrence/Span Code and From and Thru - Enter the appropriate occurrence code in the Occurrence/Span Code field. Enter the dates in the From and Thru fields. See UB-04 form locator 32-36 for specific code information. *Required, if applicable.*
Payer Code – Prior Payment- Click the drop-down arrow and highlight the appropriate payer code in the Payer Code field. Enter the dollar amount with dollars and cents (for example: Correct 45.00, Incorrect: $45 or $45.00) in the Prior Payment field (the amount that has been received prior to this payment from the payer, which is the other insurance carrier). If Medicare made a payment, these claims must be submitted on paper. Enter the dollar amount due using dollars and cents (for example: Correct: 45.00; Incorrect: $45 or $45.00) in the Estimated Due field. *Optional.*
Detail Information
From DOS and To DOS - Enter the date in which the service performed started and ended in the From DOS field and To DOS field, respectively. *Required.*
Revenue Code - Enter the three-digit revenue code in the Revenue Code field. Do not use the 001 revenue code for DDE claims. *Required.*
HCPCS/Rates - Enter the five-digit HCPCS or CPT procedure code in the HCPCS/Rates field. *Required, if applicable*. See UB-04 form locator 44 for more information.
Modifiers - Enter the modifiers in the Modifiers field. *Required, if applicable.*
Units - Enter the number of units billed at the detail level in Units field. *Required.* See UB 04 form locator 46 for more information.
Units of Measurement – Indicate the type of measurement by using the drop-down menu in the Units of Measurement field. *Required.*
Charges - Enter the amount billed (units billed multiplied by the rate) in the Charges field. *Required.*

DDE Institutional Claim Submission Instructions
Co-Pay - Enter the co-pay amount (two decimal points for cents) in the Co-Pay field. *Required, if applicable.*
If additional items are to be billed on this submission, click the Add button next to the line item window and repeat process. Click the Remove button to remove a line entry.
Hard-Copy Attachments
Use the Hard-Copy Attachments arrow at the end of the bar to add a hard-copy attachment. Enter an attachment control number as assigned by the provider in the Attachment Control Number (ACN) field. The transmission code is entered in the Transmission Code field by clicking on the down arrow, highlighting the appropriate code and clicking on it. Report type code can be entered into the Report Type field by clicking on the down arrow to make the selection. Free-form text can be entered into the Description field. Complete form HCA-13 "Paper Attachment to Electronic Claims," and mail or fax the ACN form. See Section F in this chapter for instructions on completing the HCA-13. ACNs cannot be made up of special characters or include spaces. *Required, if applicable.*
Submit - When finished, click the Submit button. *Required.*

SECTION D: ADA 2006, DENTAL, 837D



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

ADA 2006 FIELD DESCRIPTION

The ADA 2006 paper claim form is the required claim form used by dental providers for dental service billing. The provider is responsible for purchasing the ADA 2006 paper claim form. This section explains how to complete a paper ADA 2006 claim form. Please mail paper claims to the appropriate mailbox address below: The form locator chart indicates which fields are *optional*, *required* or *required, if applicable*.

Dental ADA form
HP Enterprise Services
P.O. Box 18110
Oklahoma City, OK 73154

Form Locator	ADA 2006 Field Description/Explanation
1	Type of Transaction – Enter an X in the appropriate box. Use the EPSDT/TXIX box or Oklahoma SoonerCare billing. *Required.*
2	Predetermination/Preauthorization Number – *Optional.*
3	Primary Payer Information • Carrier Name – Enter SoonerCare here. • Carrier Address – Enter the P.O. Box, which can be found in the General Information chapter of this manual. • City – Enter the city name. • State – Enter the two-letter initial of the state. • Zip – Enter the zip code. Optional.
4	Other Dental or Medical Coverage? – Enter an X in the appropriate box. *Required, if applicable.*
5	Name of Policyholder/Subscriber - The dental insurance carrier name goes in this field. This carrier must be billed before billing Oklahoma SoonerCare. *Required, if applicable.*
6	Date of Birth – This field is not used for Oklahoma SoonerCare billing.
7	Gender – Enter an X in the appropriate box. Optional.
8	Subscriber Identifier (SSN or ID#) - This field is not used for Oklahoma SoonerCare billing.
9	Plan/Group Number – Enter the number of the insurance company here. *Optional.*
10	Patent's Relationship to Person Named in # 5 – Check appropriate box. *Optional.*

Form Locator	ADA 2006 Field Description/Explanation
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code – This field is used for payment information and/or denial information from the patient's other dental insurance. If a payment is received from patient's primary insurance, put the amount of the payment in this field (for example, 45.00). You do not need to use a dollar sign ($). If the primary insurance carrier did not make reimbursement, write the words, "Carrier Denied" in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims. *Required, if applicable.*
12	Policyholder/Subscriber Name - Enter the member's name in last name, first name, middle initial order, address, city, state, and zip code. *Optional.*
13	Date of Birth –This field is not used for Oklahoma SoonerCare billing. *Optional.*
14	Gender – Enter an X in the appropriate box. *Optional.*
15	Policyholder/Subscriber ID (SSN or ID) - This field is not used for Oklahoma SoonerCare billing. *Optional.*
16	Plan/Group Number – Enter the member's or employer group's plan or policy number. This may also be known as the certificate number. *Optional.*
17	Employer Name – Enter SoonerCare. *Optional.*
18	Relationship to Member/Employee: - Check the Self box. *Optional.*
19	Student Status – Check appropriate box, if applicable. *Optional.*
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code - Enter the member's name in last name, first name, middle name order as it appears on their eligibility file. *All required except address, city, state, and zip code, which are optional.*
21	Date of Birth (MM/DD/YY) – Enter member's date of birth using MM/DD/YY format. *Optional.*
22	Gender – Enter an X in the appropriate box. *Optional.*
23	Patient ID/Account # - Enter patient's nine-digit Oklahoma SoonerCare ID number. *Required.*
24 through 31 – Only one unit may be billed per detail line.	
24	Procedure Date – The date of service must be entered in MM/DD/CCYY format. *Required.*

Form Locator	ADA 2006 Field Description/Explanation
25	Area of Oral Cavity - The following are the only acceptable quadrants: UL –Upper Left; UR – Upper Right; LL – Lower Left; LR – Lower Right *Required, if applicable.*
26	Tooth System - *Optional.*
27	Tooth Number(s) or Letter(s) – (if applicable). Must use the international tooth numbering system for permanent, primary teeth, and supernumerary teeth. *Required, if applicable.*
28	Tooth Surface - The following are the only acceptable surfaces: M - Mesial D - Distal O - Occlusal L - Lingual F - Facial B - Buccal I - Incisal *Required, if applicable.*
29	Procedure Code- This is the five-digit HCPCS code listed in the current HCPCS Level II code book. *Required.*
30	Description – Use this field to enter any additional information. *Optional.*
31	Fee - Enter your customary fee for the procedure. *Required.*
32	Other Fee(s) – Payment amounts made by other insurance plans. This field is not used for Oklahoma SoonerCare billing.
33	Total Fee - Enter the total of column 31 charges. Each page must have a total. Claims cannot be continued to two or more pages. *Required.*
34	Place an X on each missing tooth – Identify all missing teeth by using the international tooth numbering system for permanent and primary teeth to mark an "X" on numbers and letters corresponding with those teeth. *Optional.*
35	Remarks –*Optional.*
36	Patient/Guardian Signature – Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.
37	Subscriber Signature - Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.
38	Place of Treatment – Enter an X in the appropriate box. If left blank, it will default to Provider's Office selection. *Required, if applicable.*
39	Number of Enclosures (00-99) – *Optional.*
40	Is treatment for orthodontics? – Enter X in appropriate box. If the No box is marked, skip form locators 41 and 42. *Optional.*
41	Date Appliance Placed (MM/DD/CCYY) – Enter date orthodontic appliance was placed. *Optional.*

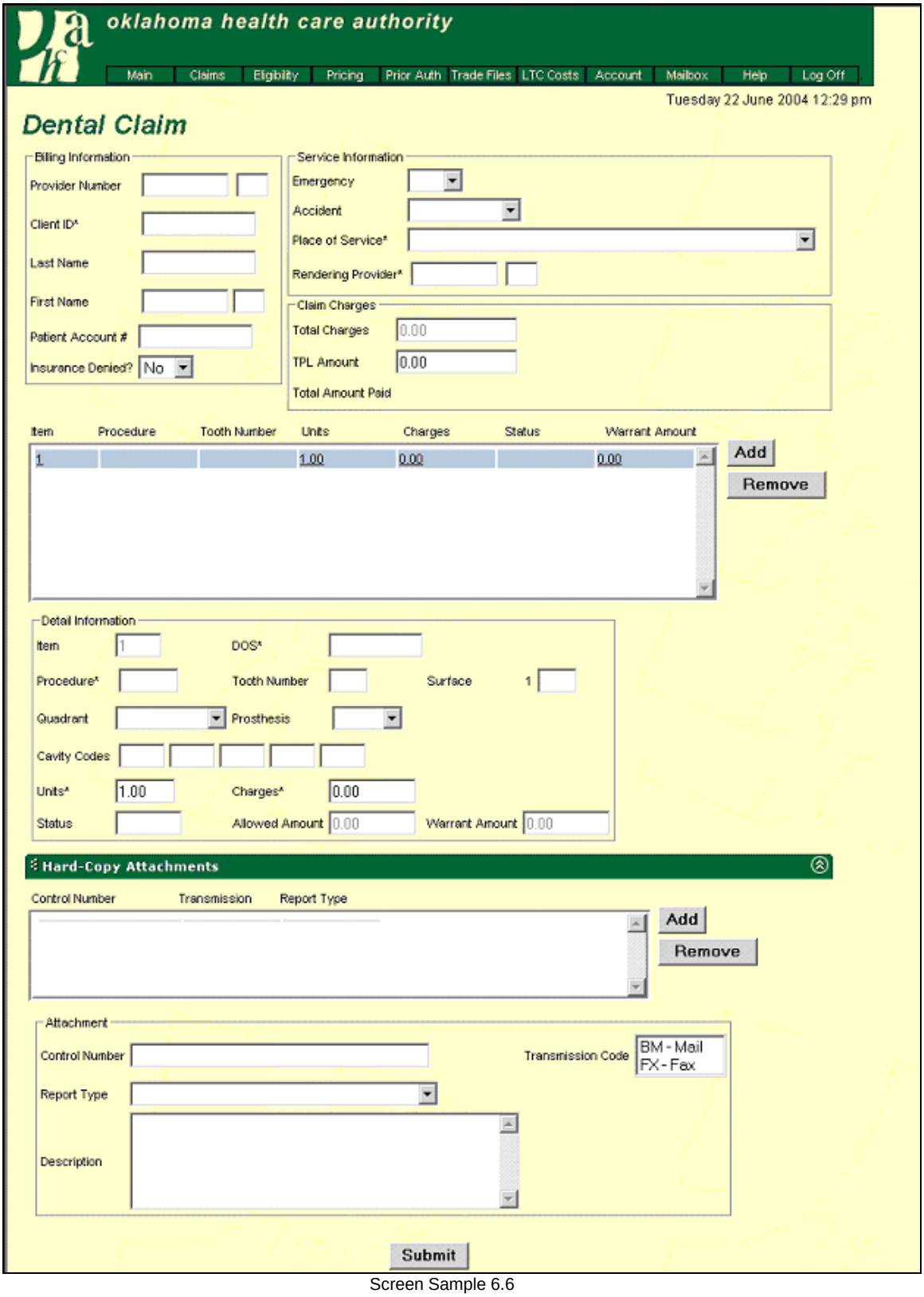
Form Locator	ADA 2006 Field Description/Explanation
42	Months of Treatment Remaining – Enter number of months of treatment remaining for appliance. *Optional.*
43	Replacement of Prosthesis? – Enter X in appropriate box. *Optional.*
44	Date Prior Placement (MM/DD/CCYY) – Enter date of previous placement. *Optional.*
45	Treatment Resulting From - Check applicable box. *Required, if applicable.*
46	Date of Accident - Enter date accident occurred in MM/DD/CCYY format. *Optional.*
47	Auto Accident State – Enter state where accident occurred. *Optional.*
48	Name, Address, City, State, Zip Code of Billing Dentist or Billing Entity – Enter the name, address and zip code of dentist requesting payment for services listed on claim form. If the dentist furnished the services as part of a dental group practice, enter the name, address, zip code and telephone number of the dental group practice. *Required.*
49	NPI – Enter the NPI for the pay-to provider if the services were furnished as part of a group practice. *Optional.*
50	License Number –*Optional.*
51	SSN or TIN – *Optional.*
52	a – Enter the phone number, including area code, of the billing dentist telephone number for the billing provider's office. *Optional.*
52a	Enter the 10-character Oklahoma SoonerCare provider number for the billing group. *Required, if dentist is part of a group.*
53	Treating Dentist's signature and date of claim – The name of the treating dentist and the date the claim was created. A signature stamp is acceptable; however, writing *Signature on File* is not allowed. *Required.*
54	NPI – Enter the NPI of the individual dentist providing the service. *Optional.*
55	Dentist License # - Enter the license number of the billing dentist. *Optional.*

Form Locator	ADA 2006 Field Description/Explanation
56	Address, City, State, Zip Code where treatment was performed Address - Enter address if different from address indicated in box 48. *Required, if applicable.* City – Enter city if different from city indicated in box 48. *Required, if applicable.* State – Enter two-letter state initial if different from state indicated in box 48. *Required, if applicable.* Zip Code – Enter zip code if different from zip code indicated in box 48. *Required, if applicable.* *56A.* Provider Specialty Code. Enter the treating provider's specialty area. *Optional.*
57	Phone Number – Enter phone number of office where treatment was performed. *Optional.*
58	Additional Provider ID - Enter the rendering dentist's 10-character Oklahoma SoonerCare provider number. *Required.*

DIRECT DATA ENTRY (DDE) CLAIM SUBMISSION (DENTAL)

Use the Dental claim form example and directions below as guides when submitting a claim through DDE on Medicaid on the Web. Required fields are indicated in the directions. To access the form, choose the 'Submit Dental' (see Screen Sample 6.5) claim option from the Claims drop-down menu.

Screen Sample 6.5



Screen Sample 6.6

DDE Dental Claim Submission Instructions
Billing Information
Provider Number - Your Provider ID should appear in the first box. Confirm it is correct. If it is not, you may need to log out and access the correct provider. *Required.*
Client ID - Enter the member's Oklahoma SoonerCare ID number in this field. The patient's last name and first name will auto populate if the Member ID entered is found in the system. *Required.*
Patient Account # - The patient account number will be captured and appear on the remittance advice, if entered into this field. *Optional.*
Insurance Denied – If there is other insurance involved and the primary carrier denied the charges or allowed coverage but did not make a payment (for example: applied to deductible), select "Yes." If the primary carrier made a payment or if there is no other insurance involved, select "No." *Required, if applicable.*
Service Information
Emergency - Specify whether the claim was an emergency by selecting "Yes" or "No." *Optional.*
Accident - If claim is related to an accident, select accident from the drop-down list. *Required, if applicable.*
Place of Service – Select the appropriate place of service from the drop-down list. *Required.*
Rendering Provider – Enter the 10-character SoonerCare provider identification number of the dentist performing the services. Leave this field blank if the rendering provider is the same as the billing provider. *Required, if applicable.*
Claim Charges
Total Charges – Total Charges field is automatically populated.
TPL Amount - Enter any amounts paid by other payers. If no other insurance is involved or has paid on this claim, leave this field at 0.00.
Detail Information
DOS - Enter the date of service here. *Required.*
Procedure - Enter the procedure code in this field. *Required.*
Tooth Number - Enter tooth number in this field. *Required, if applicable.*
Surface – Enter surface in this field. *Required, if applicable*.
Quadrant - Choose the quadrant. *Required, if applicable.*
Prosthesis – Choose, if applicable, from the options available. *Optional.*
Cavity Codes - Enter modifier codes in the Cavity Code fields. *Required, if applicable.*
Units - Enter number of units billed in this field. *Required.*

DDE Dental Claim Submission Instructions
Charges - Enter the total dollar amount of charges in this field for this line of service. This action will auto-populate the Total Charges field, but it will not multiply the amount by the number of units. *Required.*
If additional items are to be billed on this submission, click the Add button next to the line item window and repeat process. Click the Remove button to remove a line entry.
Hard-Copy Attachments
If a hard-copy attachment is to be added, use the 'Hard-Copy Attachments' arrow at the end of the bar. Enter an attachment control number as assigned by the provider in the Attachment Control Number (ACN) field. The transmission code is entered in the Transmission Code field by clicking on the down arrow, highlighting the appropriate code and clicking on it. Report type code can be entered into the Report Type field by clicking on the down arrow to make the selection. Text can be entered into the Description field. Complete form HCA-13 "Paper Attachment to Electronic Claims," and mail or fax the attachment control number form. See Section F in this chapter for instructions on completing form HCA-13. Attachment control numbers cannot be made up of special characters or include spaces. *Required, if applicable.*
Submit - When finished, click on the Submit button.

SECTION E: DRUG/COMPOUND PRESCRIPTION DRUG , PHARMACY, NCPDP

State of Oklahoma
Oklahoma Health Care Authority

Prescription Drug Claim Form

PLEASE PRINT CLEARLY

Provider Number (required) 01	Loc (req) 02	Billing NPI (optional) 03	Telephone Number 04

Patient's Name: Last, First (required) 05	Member ID (Required). 06	Member's Date of Birth (Required mmddccyy) 07	Emergency (Y or N) 08	Pregnancy (Y or N) 09	NH Pt. (Y or N) 10

Prescription Number (Required) 11	Date Prescribed (Required) 12	Date Dispensed (Required) 13	NDC Number (Required) 14	Quantity (required) 15	Days 16

Brand Medically Necessary 17	Refill 18	Individual Prescriber's ID Number (Required) 19	Individual Prescriber's Name: Last, First (Required) 20

Charge (Required) 21	Third Party Paid 22	Total Amount Billed (Required) 23	Usual and Customary 24

Provider's Name and Address 25	This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law. I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.	
	Signature of Provider or Representative (Required) 26	Date Billed (Required) 27

Mail Completed Claim Form to:
EDS
P.O. Box 18650
Oklahoma City, OK 73154

OKLA HCA Revised 04/17/2007 PHARM-1

FIELD DESCRIPTIONS FOR DRUG/COMPOUND CLAIM FORMS

The Drug/Compound Drug Claim Forms are used to bill pharmacy services and are available in the Forms chapter of this manual and on the OHCA Web site at www.okhca.org.

Pharmacy Claim submissions are done through the Drug Claim Form (Pharm-1 revised 4/17/2007) and Compound Prescription Drug Claim Form (Pharm-2). These claim forms should be used for all pharmacy paper billing, including the resubmission of a claim that is more than one year past date of service. The form locator chart indicates which fields are *optional*, *required* or *required, if applicable*.

Please mail paper claims to:

Pharmacy
HP Enterprise Services
P.O. Box 18650
Oklahoma City, OK 73154

Form Locator	Pharmacy Drug Field Description/Explanation
01	Provider Number – Enter the 9 numeric Oklahoma SoonerCare provider number. *Required.*
02	Loc – Enter the alpha location code of the Oklahoma SoonerCare provider number. *Required.*
03	Billing NPI – Enter the NPI of the billing provider. *Optional.*
04	Telephone Number – *Optional.*
05	Patient's Name – Enter the patient's name in last, first format. *Required.*
06	Member ID Number – Enter the patient's nine-character Oklahoma SoonerCare identification number. *Required.*
07	Member's Date of Birth – Enter the member's date of birth in a month, day, century, year format. (mmddccyy) *Required.*
08	Emergency – Enter "Y" for Yes or "N" for No if prescription is related to an accident. *Optional.*
09	Pregnancy– Enter "Y" for Yes or "N" for No if prescription is related to a pregnancy. *Optional*.
10	NH Pt. – Enter "Y" for Yes or "N" for No if prescription was dispensed to a resident of a nursing home facility. *Optional.*
11	Prescription Number – Enter the pharmacy's prescription number. May be up to seven characters in length. *Required.*

Form Locator	Pharmacy Drug Field Description/Explanation
12	Date Prescribed – Enter the date the prescription was written. Must be on or before receipt date; not a future date. *Required.*
13	Date Dispensed – Enter the date the prescription was dispensed. Must be on or before receipt date; cannot be future date. *Required.*
14	NDC Number – Enter the 11-digit National Drug Code (NDC) number of the drug dispensed. *Required.*
15	Quantity – Enter the metric quantity to three decimal places, up to 11 characters. Example: 99999999.999 *Required.*
16	Days– Enter the number of days supply dispensed. May be up to three characters. *Required.*
17	Brand Medically Necessary – Enter the appropriate brand name indicator as indicated below: 0 – No product selection indicated 1 – Substitution not allowed by prescriber – Dispense as written. *Required, if applicable.*
18	Refill – Enter two digits to indicate the number of times the prescription has been dispensed. Example: 00 = original dispensing, 01 to 99 = refill number. *Required*
19	Individual Prescriber's ID Number – Enter the seven-digit Oklahoma Prescriber ID number of the prescribing physician. *Required.*
20	Individual Prescriber's Name – Enter the prescriber's name. Last name followed by first name. *Required.*
21	Charge – Enter the charge for this prescription. *Required.*
22	Third Party Paid – Enter the amount paid by the primary insurance (TPL). *Required, if applicable.*
23	Total Amount Billed – Enter the total amount billed. Charge – TPL = total amount billed. *Required.*
24	Usual and Customary – Enter the usual and customary charge for the quantity and NDC provided. *Required.*
25	Provider's Name and Address – Enter the billing provider's name, address and telephone number. *Optional.*
26	Signature of Provider or Representative - This must be an authorized name of a person indicating that the information entered in the face of this bill is in conformance with the certifications listed on the form. A stamped signature is acceptable, but writing *signature on file* is not acceptable. *Required.*
27	Date Billed - Enter the date the bill is submitted in MMDDYY format. *Required.*

[redacted]

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
COMPOUND PRESCRIPTION
DRUG CLAIM FORM

PLEASE PRINT CLEARLY

Provider Number 1	Loc	Telephone Number 2

PATIENT'S NAME: LAST, FIRST 3	CLIENT NO. 4	PRESCRIBER'S I.D. NUMBER 5	EMERG 6	PREG 7	N.H. PAT 8	BRAND 9	REFILL 10

PRESCRIPTION NUMBER 11	DATE PRESCRIBED 12	DATE DISPENSED 13	LOCAL USE ONLY 14	DAYS 15	CHARGE 16	3rd PARTY PAID 17

LINE NUMBER	NDC NUMBER 21	DESCRIPTION OF INGREDIENT 22	QUANTITY 23
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Provider's Name and Address

18

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of Provider or Representative

19

Date Billed

20

MAIL COMPLETED CLAIM FORM TO:
EDS
P.O. Box 18650
Oklahoma City, OK 73154

OKLA HCA Issued 11/01/04 Pharm-2

COMPOUND PRESCRIPTION DRUG CLAIM FORM INSTRUCTIONS

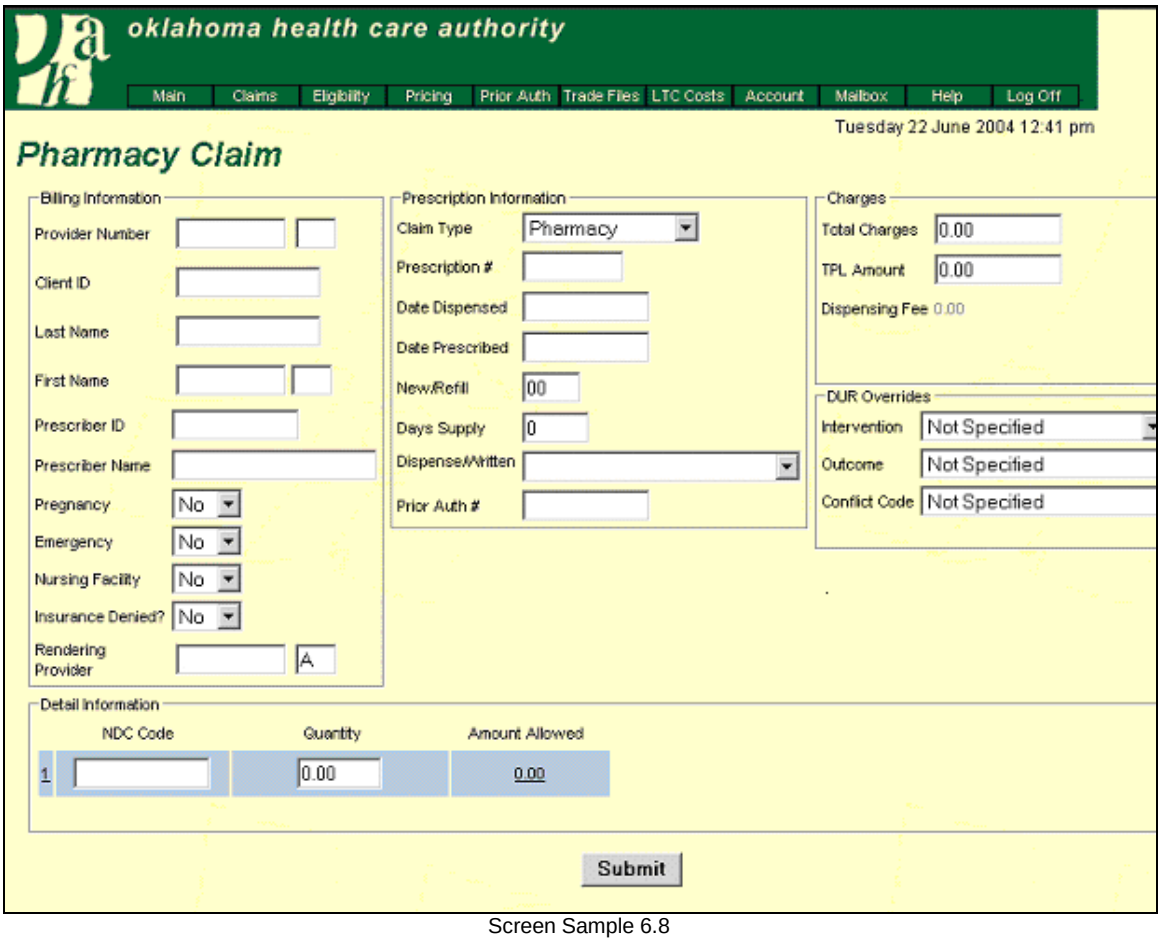
Form Locator	Compound Prescription Drug Field Description/Explanation
1	Provider Number – Enter the 10-character Oklahoma SoonerCare provider number and Location code. *Required.*
2	Telephone Number – *Optional.*
3	Patient's Name – Enter the member's name in last, first format. *Required.*
4	Client ID Number – Enter the member's nine-character Oklahoma SoonerCare identification number. *Required.*
5	Prescriber ID Number – Enter the seven-digit Oklahoma Prescriber ID number of the prescribing physician. *Required.*
6	Emerg – Enter "Yes" or "No" if prescription is related to an emergency. *Optional.*
7	Preg – Enter "Yes" or "No" if prescription is related to a pregnancy. *Optional.*
8	N. H. PAT – Enter "Yes" or "No" if prescription was dispensed to a resident of a nursing home facility. *Optional.*
9	Brand – Brand Name Indicator 0 – No product selection indicated 1 – Substitution not allowed by prescriber – Dispense as written. *Required, if applicable.*
10	Refill – Refill Indicator. Enter two digits to indicate the number of times the prescription has been dispensed. Example: 00 = original dispensing, 01 to 99 = refill number. *Required.*
11	Prescription Number – Enter the pharmacy's prescription number. May include up to seven characters. *Required.*
12	Date Prescribed – Enter the date the prescription was written. Must be on or before receipt date; not a future date. *Required.*
13	Date Dispensed – Enter the date the prescription was dispensed. Must be on or before receipt date; not a future date. *Required.*
14	Local Use Only – *Not applicable.*
15	Days – Enter the number of days supply dispensed. May be up to three characters. *Required.*
16	Charge - Enter the total charges for this claim. *Optional.*
17	3rd PTY Paid – Enter the amount paid by the primary insurance. *Required if applicable.*

Form Locator	Compound Prescription Drug Field Description/Explanation
	Service Lines
21	NDC Number - Enter the 11-digit National Drug Code (NDC) number of each of the drugs dispensed. *Required.*
22	Description of Ingredient – List each ingredient with the corresponding NDC. *Required.*
23	Quantity – List the quantity of each ingredient in this compound drug.
	Billing Information
18	Provider's Name and Address – Provider name, address and telephone number. *Optional.*
19	Signature of Provider or Representative - This must be an authorized name of a person indicating that the information entered in the face of this bill is in conformance with the certifications listed on the form. A stamped signature is acceptable, but writing signature on file is not acceptable. *Required.*
20	Date Billed/Date of Claim Submission - Enter the date the bill is submitted in MMDDYY format. *Required.*

DIRECT DATA ENTRY (DDE) CLAIM SUBMISSION-PHARMACY (INCLUDING COMPOUNDS)

Use the Pharmacy claim form example and directions below as guides when submitting a claim through DDE on Medicaid on the Web. To access the form, choose the "Submit Pharmacy" claim option (see Screen Sample 6.7) from the Claims drop-down menu.

Screen Sample 6.7



Screen Sample 6.8

Pharmacy Claim Submission Instructions
Billing Information
Provider Number - Your Provider ID should appear in the first box. Confirm that it is correct. If it is not, you may need to log out and access the correct provider. *Required.*
Client ID - Enter the member's Oklahoma SoonerCare ID number in this field. (The member's last name and first name will auto populate if the member ID entered is found in the system). *Required.*
Prescriber ID – Enter the seven-digit Oklahoma Prescriber ID number of the prescribing physician. *Required.*
Prescriber Name – Enter the last name of the prescribing physician. *Required.*
Pregnancy – Select the appropriate answer of "Yes" or "No" indicating whether or not this prescription was related to a pregnancy. *Optional.*
Emergency - Select the appropriate answer of "Yes" or "No" indicating whether or not this prescription was related to an emergency. *Optional.*
Nursing Facility - Select the appropriate answer of "Yes" or "No" indicating whether or not this prescription was dispensed to a resident of a nursing home facility. Optional.
Insurance Denied – If there is other insurance involved and the primary carrier denied the charges or allowed coverage but did not make a payment (for example: applied to deductible), select "Yes." If the primary carrier made a payment or if there is no other insurance involved, select "No." *Required, if applicable.*
Rendering Provider - This field will automatically populate with the same Provider ID found (automatically populated) in the Provider Number field. *Required.*

Prescription Information
Claim Type – Select whether the current prescription is a regular pharmacy claim or a compound drug pharmacy claim. *Required.*
Prescription # - Enter the pharmacy assigned prescription number (up to seven digits) for the current prescription. *Required.*
Date Dispensed – Enter the date the prescription was dispensed by the pharmacy. *Required.*
Date Prescribed – Enter the date the prescription was prescribed by the physician. *Required.*
New/Refill – Enter two digits to indicate the number of times the prescription has been dispensed. Example: 00 = original dispensing, 01 to 99 = refill number. *Required.*
Days Supply – Enter the number of days the prescription will cover. *Required.*

Pharmacy Claim Submission Instructions
Dispense/Written – Select the most appropriate option from the drop-down menu to indicate if the prescription was dispensed as prescribed (dispensed as written) or if a generic medication was substituted. *Required.*
Prior Auth # - Enter the applicable Prior Auth or Super PA for claim. If no PA was obtained, leave this field blank. *Required, if applicable.*

Charges

Total Charges – Enter the total amount being billed for this prescription in this submission. *Required.*
TPL Amount – Enter the amount paid on this claim by the primary insurance carrier prior to billing SoonerCare. If no other insurance is involved or has made no payment on this claim, leave this field at 0.00. *Required.*

DUR Overrides

Intervention – Select the appropriate Prospective DUR intervention used to decide outcome of claim. *Required, if applicable.*
Outcome – Select the appropriate Prospective DUR outcome that was made using the intervention. *Required, if applicable.*
Conflict Code – Select the Prospective DUR conflict code that is to be overridden using the intervention and outcome code. *Required, if applicable.*

Detail Information

NDC Code – Enter the 11-digit National Drug Code (NDC) number of the drug dispensed. *Required.*
Quantity – Enter the quantity being dispensed for the above NDC within the prescription. *Required.*
Click on the Submit button when finished.

SECTION F: ELECTRONIC CLAIM FILING ATTACHMENT FILING

Proper filing of attachments to electronic claims is essential to the successful payment of submitted claims with attachments. An important part of the filing process is accurate entry of provider, member, and ACNs on the electronic claim form and the HCA-13 cover sheet. The instructions on how to complete the form are listed below, with an image of the DDE screen illustrated in Screen Sample 6.9.

Provider Number – Enter the 10-character Oklahoma SoonerCare provider ID number of the provider submitting the claim.

Recipient Number – Enter the member's 9- digit Oklahoma SoonerCare identification number.

Attachment Control Number– Enter the ACN that was listed on the DDE screen when the claim was submitted.

Once completed, fax the form to 405-947-3394 or mail to:

HP Enterprise Services
P.O. Box 18500
Oklahoma City, OK 73154

HELPFUL TIPS

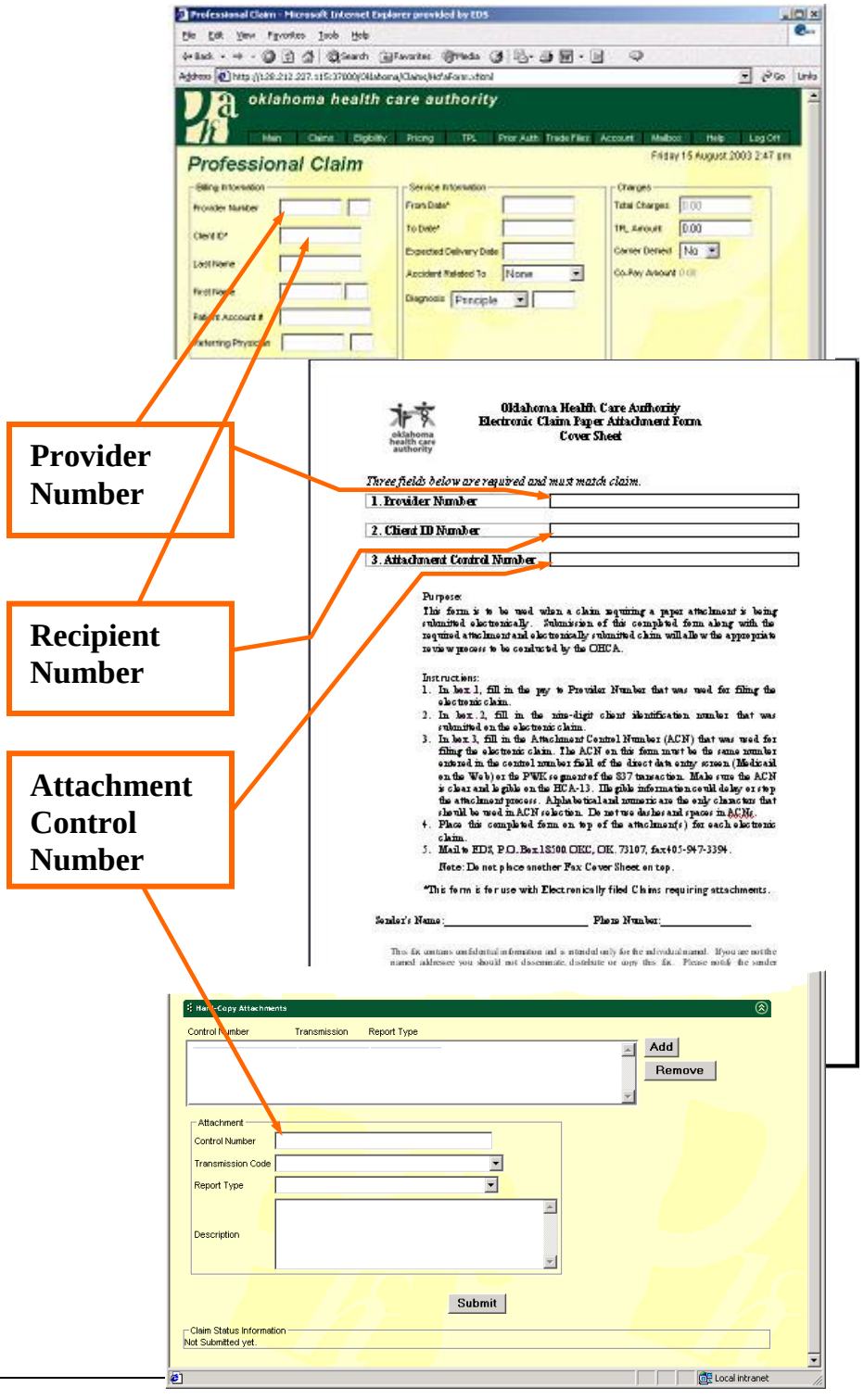
Make sure the ACN on the form HCA-13 matches the ACN placed on the claim: The HCA-13 and the claim will match when done correctly. The same ACN goes into the Attachment Control Number field of the HCA-13 cover sheet that was entered in the Control Number field on the direct data entry screen (Medicaid on the Web) or the PWK segment of the 837 transactions.

Use the counter to distinguish claim submissions: If a claim needs to be submitted a second time, using a counter number added to the ACN will assist in the information being matched on the next submission. (for example: original ACN is 123456; second ACN for the same claim is 123456**01**) Please make sure that the claim and the HCA-13 have been updated with the correct counter.

Be sure to enter the correct provider number: Enter the billing/pay-to provider number; not the rendering or performing provider numbers, on the HCA 13.

Submit information legibly: Make sure your number is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Alphabetical and numeric are the only characters that should be used in the ACN selection. Do not use dashes, spaces and special characters in the ACN.

Avoid using confidential member information as an ACN: Refrain from using the member's Social Security number, date of birth, or name as an ACN. These are easily identifiable or specific to the identification of the member, which is in direct violation of HIPAA. Account numbers can be used as long as they are facility/office specific.



Screen Sample 6.9

SECTION G: MEDICARE-MEDICAID CROSSOVER INVOICE

The OHCA recently developed the Medicare-Medicaid Crossover Invoice form to be used when submitting paper crossover claims. Use this form as a supplement to the Medicare Explanation of Benefit (EOB) statement attachment previously required on paper cross-over claims. The new form was created due to multiple versions of the Medicare (EOB) statements being printed from the different software formats currently available. The information needed to be keyed from the Medicare EOB to process cross-over claims no longer appears in a standard format when printed. This means the needed information to be keyed appears differently and is marked with different headers on each printed electronic Medicare EOB, making cross-over claim processing challenging. The Medicare-Medicaid Crossover Invoice form will allow these claim types to be keyed faster and more accurately by removing interpretations.

Medicare-Medicaid
Crossover Invoice

ONE INVOICE PER CLAIM

Header 1	
SoonerCare Provider ID:	
Member ID	Member Name First: Last:
Patient Control Number	
Medicare HIC Number	
From DOS: To DOS:	

Header 2	
Total Billed: $	
Date Paid:	
Coinsurance: $	Medicare Remark Code :
Deductible: $	Medicare Remark Code :
Blood Deductible: $	
Total Allowed: $	Medicare Remark Code :
Medicare Remark Code :	
Amount Paid: $	Medicare Remark Code :

Mail claims for payment to:
EDS
P.O. Box 18110
Oklahoma City, OK 73154

Provider Signature Date Signed

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Header 1
SoonerCare Provider ID - Enter the 10-character SoonerCare provider ID. This consists of the 9 numeric chracters and 1 alpha character or 10-character ID number. *Required.*
Member ID - Enter the member's nine-character Oklahoma SoonerCare identification number. *Required.*
Member Name - Enter the member's name in first name, last name order. *Required.*
Patient Control Number - Enter the internal patient account number. This number will appear on the remittance advice. *Required.*
Medicare Number - Enter the member's Medicare number. *Required.*
From DOS to DOS - Enter the from and through dates of service as indicated on the Medicare EOB for the indicated claim using the MM/DD/YY formats. *Required.*

Header 2
Total Billed - Enter the total amount billed for all detail lines. *Required.*
Date Paid - Enter the date the claim was paid by Medicare in the MM/DD/YY format. *Required.*
Coinsurance/Medicare Remark Code - Enter the amount of the coinsurance for the total Medicare claim and the corresponding Medicare Remark Code(s). *Required, if applicable.*
Deductible - Enter the amount of the deductible for the total Medicare claim and the corresponding Medicare Remark Code(s). *Required, if applicable.*
Blood Deductible - Enter the amount of the indicated Blood Deductibles on the Medicare claim. *Required, if applicable.*
Total Allowed - Enter the total allowed amount for the entire Medicare claim and the corresponding Medicare Remark Code(s).
Medicare Remark Code - Enter Medicare Remark Code(s) that corresponds to entire claim.

Chapter 7

Electronic Data Interchange

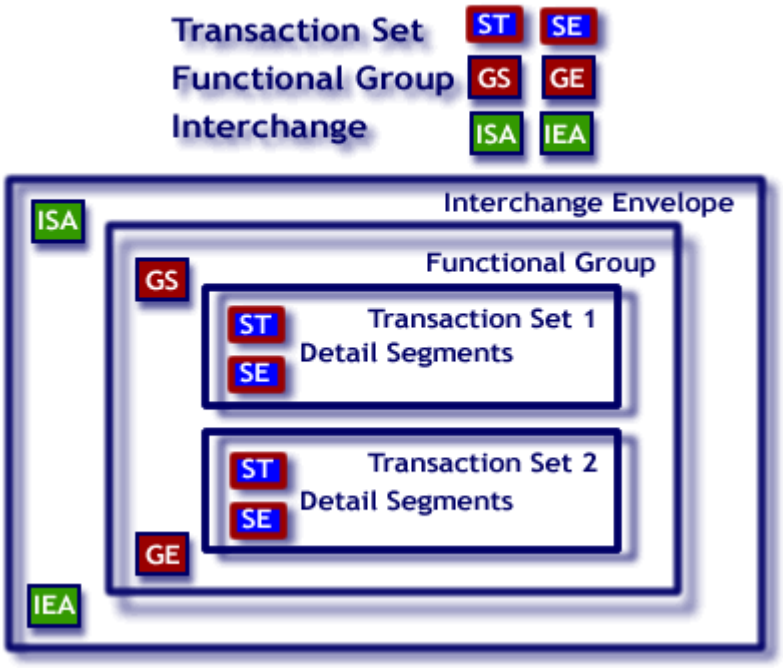
INTRODUCTION

Electronic Data Interchange (EDI) is the most efficient method of submitting and receiving large amounts of information within the Oklahoma Medicaid Management Information System (OKMMIS).

Some benefits of EDI include

- Improved accuracy;
- lowered operating costs;
- increased cash flow;
- shorter payment turnaround time;
- ability to check claims status electronically; and
- increased accounts receivable timeliness and functionality.

In addition, there is no charge to providers for EDI submission. EDI transactions are sent in "envelope" information structures as detailed below:



The first step to becoming an electronic claims submitter is to complete an EDI application form. The form is found on the OHCA Web site at www.okhca.org or by contacting the EDI Help Desk.

Providers may take advantage of the EDI process by using a billing agency, clearinghouse or VAN/third party vendor approved by the fiscal agent.

EDS promotes the use of electronic claims submissions through EDI. The EDI team is available to provide direction, answer questions and assist providers or billing agents with the submission of electronic transactions.

EDI RESOURCES

OKMMIS-specific companion guides and National Council of Prescription Drug Programs (NCPDP) payer sheets are available on the OHCA public Web site at: www.okhca.org

Implementation Guides are available from the Washington Publishing Company at www.wpc-edi.com

The EDI Help Desk can be reached by phone at 800-522-0114 or at 405-522-6205.

Written correspondence for the EDI Help Desk can be sent to:

HP Enterprise Services – EDI Help Desk
2401 NW 23rd Street, Suite 11
Oklahoma City, OK 73107

SECTION A: PROFESSIONAL CLAIMS (837 PROFESSIONAL)

837 PROFESSIONAL TRANSACTION

The ASC X12N 837 Professional transaction is the electronic equivalent for the 1500 paper claim form.

Key Notes:

- No more than 50 service lines are allowed per claim.
- The REF segment (Bill-to Provider's Secondary ID #) in Loop 2010AA must be included and have the "1D" field qualifier and the provider's Medicaid ID #.
- The PAT segment, Loop 2000C and 2010CA, is no longer needed unless billing a claim for a newborn. All SoonerCare subscribers have their own SoonerCare ID number. When the subscriber and the patient are the same person, omit the PAT information in Loop 2000C and 2010CA.
- The SoonerCare numbers sent on all claims should follow this format:
  - Providers –100000000A (9 digits with 1 letter at the end, total of 10 characters).
  - Subscribers – 123456789 (9 digits, no letters).
- No more than 5,000 claims per transaction set are allowed.

SECTION B: INSTITUTIONAL CLAIMS (837 INSTITUTIONAL)

837 INSTITUTIONAL TRANSACTION

The ASC X12N 837 Institutional transaction is the electronic equivalent of the UB-92 paper claim form. All hospitals and institutional facilities must use the 837 Institutional transaction to bill electronically for services covered under the SoonerCare program.

Key Notes:

- The 837 Institutional transaction must be used for all inpatient claims.
- Providers must use their 10-digit Oklahoma Medicaid ID number as the billing/pay-to provider ID.
- Limit each transaction set to 5,000 claims.
- Limit each claim to a maximum of 50 service lines.
- For attending, operating and other physicians, please use either the physician's seven-digit prescriber number or the physician's 10-digit SoonerCare ID number as the secondary identifier in the appropriate REF segment.
- The physician's taxonomy code is not used for operating physicians or physicians classified as "other."
- Do not use revenue code 001 as a total for all service lines included on the claim.
- Unit rate is required if revenue code is 100-219 (SV02-06).

SECTION C: DENTAL CLAIM (837 DENTAL)

837 DENTAL TRANSACTION

The ASC X12 837 Dental transaction is the electronic equivalent of the ADA 2002 paper claim form.

Key Notes:

- No more than 50 service lines are allowed per claim.
- The REF segment (Bill-to Provider's secondary ID number) in Loop 2010AA must have the "1D" field qualifier and the provider's SoonerCare ID number.
- The PAT segment, Loop 2000C and 2010CA, is no longer needed unless billing a claim for a newborn. All SoonerCare subscribers except newborns have their own SoonerCare ID number. When the subscriber and the patient are the same person, omit the PAT information in Loop 2000C and 2010CA.

- The SoonerCare numbers to be sent on all claims should follow this format:
  - Providers –100000000A (9 digits with 1 letter at the end for a total of 10 characters)
  - Subscribers – 123456789 (9 digits, no letters)
- The tooth quadrant in field SV30401 must be listed.
- The TOO segment must be populated indicating tooth number and surface code.
- No more than 5,000 claims per transaction.

SECTION D: PHARMACY CLAIMS

PHARMACY CLAIMS

All interactive electronic pharmacy claims should be submitted using the NCPDP version 5.1 standard. All pharmacy claims submitted electronically in batch must be in NCPDP version 1.1 standard.

Key Notes:

- To obtain NCPDP payer sheets, go to http://www.okhca.org and click on the Provider link. Under Claims Tools, click on Electronic Data Interchange, scroll down the page and click on the HIPAA Companion Documents link under EDI Testing process.
- 3C version is no longer accepted.
- If a pharmacy is sending a compound claim, a '2' needs to be entered in field 406-D6 in the claim segment.
- If a '2' is entered in 406-D6, the compound details must be with the claim. Each NDC number must be listed.

To send test files, the pharmacy must check with their van/switch and have them send the test to the EDS test port.

SECTION E: CLAIM INQUIRIES/RESPONSES

276 CLAIM INQUIRY TRANSACTION (BATCH)

The 276 Transaction Set is used to transmit health care claim status request/response inquiries from health care providers, clearinghouses and other health care claims adjudication processors. The 276 Transaction Set can be used to make an inquiry about a claim or claims for specific SoonerCare members. It is mandatory under HIPAA that the Oklahoma MMIS is able to accept this transaction set to create health care claim status responses.

Key Notes:

- The 276 should be limited to 5,000 inquiries per transaction set (ST-SE envelope).

- In order to return valid claim data on the 277, all data in the 276 must match the data on the claim.
- The hierarchy of the search criteria in the EDI system is:
  - provider ID;
  - recipient ID;
  - recipient ID and Name must match;
  - ICN;
  - amount billed; and
  - date of service.

277 CLAIM INQUIRY RESPONSE TRANSACTION (BATCH)

The 277 Transaction Set is used to transmit health care claim status inquiry responses to any health care provider, clearinghouse or other health care claims adjudication processors that has submitted a 276 to the OKMMIS.

Key Note:
The 277 is used solely as a response to a 276 request. The 277-Unsolicited (version 3050) is not the same thing. Refer to Section H for more information on RAs and the 277-Unsolicited.

SECTION F: ELIGIBILITY INQUIRIES/RESPONSES

270 ELIGIBILITY INQUIRY TRANSACTION (BATCH)

The ASC X12N 270 Eligibility Inquiry Transaction set is used to transmit health care eligibility benefit inquiries from health care providers, clearinghouses and other health care adjudication processors.

Key Notes
Thirteen-Month Rule – The only time to get 13 months of retrospective eligibility is at the beginning of a month. Checking at the end of the month allows you to review the past 12 months in addition to the upcoming month. Eligibility is updated toward the end of the month.

Inquiry types
- Type of insurance plan.
- Type of service performed.
- Where the service is performed.
- Where the inquiry is initiated.
- Where the inquiry is sent.

When identifying a recipient/subscriber based on the information on a 270 request, the following combinations of data are valid:

- Recipient ID only.
- SSN and DOB.
- SSN and name.

- DOB and name.
- No more than 99 inquiries per ST – SE transaction set.

271 Eligibility Inquiry Transaction

The ASC X12N 271 Eligibility Response Transaction set is used to respond to health care eligibility benefit inquiries as the appropriate mechanism.

Key Notes

- The eligibility information returned is not a guarantee of claims payment.
- A value of '1' will be returned in the 271 response for a member with active coverage. This is indicated in loop 2110C - EB01.
- The '6' value will be returned solely on the inactive coverage basis. This is also indicated in loop 2110C - EB01.

Section G: Remittance Advice (RA)

835 Remittance Advice

The 835 Transaction Set will only be used to send an Explanation of Benefits (EOB) RA. For SoonerCare, payment is separate from the EOB RA and will therefore not be affected by changes to how the provider receives payment – via paper or electronically. The 835 transaction will be available to the OHCA providers and contracted clearinghouses requesting electronic remittance advice (ERA). Providers may choose to receive ERA or paper RA, but not both.

The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. SoonerCare provides a supplemental transaction that provides claim status information on pending claims. This transaction is the 277 Health Care Payer Unsolicited Claim Status (X12 version 3050) and is available to all OHCA providers and contracted clearinghouses requesting ERA.

Key Notes

- Requests for changes in the delivery of an RA must be made in writing to the EDI team.
- ERAs may be combined and/or sent to a designated receiver via the provider's secure Internet account.

Section H: Electronic Claims or Prior Authorizations with Paper Attachments

An attachment cover sheet form HCA-13 is available for all attachments that need to be submitted with electronic claims or electronic PA requests. HCA-13 allows claims or PA request submitters to continue billing their claims or PA requests

electronically, even if an attachment needs to be sent with the claim or PA request.

To ensure proper handling of attachments:

- The attachment control number (ACN) in the PWK segment in the electronic claim or the Control field of the direct data entry page on Medicaid on the Web must be identical to the ACN field on HCA-13. (See Section F of the Claims Completion chapter in this manual.)
- The provider and recipient numbers on the claim must match the provider and recipient numbers on form HCA13.
- Each submission of a claim must have a new ACN. If resubmission of a claim occurs, a counter after the original number is suggested.
- All ACNs must be unique.
- The number must be clear and legible on HCA-13. Please do not mark out information on the form. Use a new form if a mistake is made.
- When creating ACNs, avoid using
  - dashes, spaces or any other special characters;
  - ICN (claim number);
  - phone numbers;
  - patient's date of birth; and
  - patient's SSN/FEIN.
- Copies of the Attachment Cover Sheet can be obtained
  - in the Forms Chapter of this manual;
  - on the OHCA Web site at http://www.okhca.org; or
  - by calling the HP Call Center at 405-522-6205 or 800-522-0114.

SECTION I: ELECTRONIC MEDIA TYPES

EDI transactions can be submitted to HP through a variety of electronic media types. EDI submissions generated from your computer can be transmitted via

- the OHCA secure Web site;
- remote access server (RAS);
- tape/cartridge (3480/3490); or
- CD-ROM.

EDI BATCHED ELECTRONIC TRANSACTIONS

Batch transactions/files that are sent to HP via the OHCA secure Web site or the RAS are immediately placed in the OKMMIS for processing.

HARD MEDIA

The HP-EDI department receives batch transactions and files that are sent via CD-ROM. These transactions and files are called "hard

media." An EDI representative scans the hard media for viruses and performs a visual inspection of the data to ensure it is in X12 format. If the hard media has no viruses and is in X12 format, it is placed in the OKMMIS for processing.

SECTION J: HIPAA TRANSACTION AND CODE SET REQUIREMENTS

The Health Insurance Portability and Accountability Act (HIPAA) is a national effort driven by the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) geared toward administrative simplification and electronic submission standardization. The HIPAA influences the way protected health information (PHI) is transferred and sets specific guidelines for protection of PHI used for treatment, payment and business operations.

On August 14, 2000, the DHHS issued a Final Rule for Standards for Electronic Transmissions as part of the Administrative Simplification portion of the HIPPA. Find the Final Rule at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. In October 2002, DHHS issued an addendum to the Final Rule, which was accepted in December 2002 and published in February 2003. This is the most current HIPAA compliant formatting standard for the Transaction Code Set (TCS) rule.

The OKMMIS follows the HIPAA mandated TCS standards as set forth by DHHS and CMS.

Chapter 8

Claims Resolution Process

INTRODUCTION

This chapter is designed to outline the process a claim goes through from submission to completion. By understanding this process, providers should have a better idea of how to evaluate their denied claims and how to get those claims corrected.

SECTION A: CLAIM CREATION

When paper claims are received, they are first sorted into groups related to the claim type (for example: outpatient, inpatient, dental, physician and crossovers).

Once the claims are sorted by claim type, all claims received are scanned into the Oklahoma Medicaid Management Information System (OKMMIS). The scanners translate the information into the OKMMIS by optical character recognition (OCR). This reduces the amount of human error by allowing the system to read the claims directly.

When claims are scanned into the OKMMIS, they are assigned an Internal Control Number (ICN). This number has information regarding the claim and assists the providers and the OHCA when researching a claim. An example of the ICN coding orientation is found below, followed by the coding description.

Coding orientation: R R Y Y J J J I I I I I I

Code	Description
R R	These first two digits of the ICN refer to the region code assigned to a particular type of claim. Region codes are explained later in this chapter.
Y Y	These two digits of the ICN refer to the calendar year the claim was received. For example, all claims received in calendar year 2006 would have 06 in this field.
J J J	These three digits of the ICN refer to the Julian date the claim was received. Julian dates are shown on many calendars as days elapsed since January 1. There are 365 days in a year, 366 in a leap year, so a claim received on March 17, 2004, a leap year, would have a Julian date of 077, which indicates that March 17, 2004, is the 77th day of 2004.
IIIIII	The final six digits of the ICN refer to the claim number, which is assigned when the claim comes into the EDS mailroom.

Based on this information, an ICN number of 1006032123456 indicates that the claim was received on paper (region code 10), in the year 2006 (year 06), on February 1st (Julian date 032). The remaining 6 digits are assigned as a batch sequence number by the OKMMIS, and illustrate the order in which the claim was received.

Region codes indicate the claim submission method used. More frequently used region codes are:

Code	Description
10	Paper without attachments
11	Paper claims with attachments
20	Electronic claims with no attachments
21	Electronic claims with attachments
22	Internet claims with no attachments
23	Internet claims with attachments
25	Point of service claims
26	Point of service claims with attachments
40	Claims converted from old OKMMIS
45	Adjustments converted from old OKMMIS
47	Converted history-only adjustments
49	Recipient linking claims
50	Adjustments – non-check related
51	Adjustments – check related
52	Mass adjustments – non-check related
53	Mass adjustments – check related
54	Mass adjustments – void transactions
55	Mass adjustments – provider rates
56	Adjustments – void non-check related
57	Adjustments – void check related
58	Adjustments – processed by EDS SE
59	Provider reversals/voids
80	Claims reprocessed by EDS systems engineers
90	Special projects
91	Batches requiring manual review
92	HMO Co-pays
99	Converted claims with duplicate ICN

SECTION B: DATA ENTRY

Once claims are scanned into the OKMMIS and assigned an ICN, the OKMMIS sends the claim to the data entry department. There, the required fields are keyed manually to verify that the information necessary to process the claim is complete and accurate. Once the claim data are entered, the OKMMIS will attempt to automatically adjudicate the claim. The claim will run

through two different types of edits. Please note that the following information regarding edits is very general, and should not be considered a full and comprehensive list of all the edits used by the OKMMIS system.

MMIS EDITS

OKMMIS edits are wide-ranging edits that review the claim and details from a very general perspective. OKMMIS edits will review the claims data for accuracy, and compare the claim to the member's file to check for eligibility and programs. The system will then compare the claim to the provider's file for contract effective dates and check the provider's file to ensure that the provider type is eligible to receive payment for the type of services provided. Lastly, the system will check the service lines to ensure that the services being provided are covered under Oklahoma SoonerCare, as well as checking for any policy limitations regarding units allowed, prior authorizations or age restrictions.

CLAIMCHECK EDITS

ClaimCheck edits evaluate claims for coding accuracy. ClaimCheck employs logic from three edits: Rebundling, Incidental, and Mutually Exclusive. The Rebundling edit checks are for procedure unbundling. This occurs when two or more procedure codes are used to report a service when a single and more comprehensive procedure code exists. Incidental edits check for certain procedures performed at the same time as a more complex primary procedure and are clinically integral to the successful outcome of the primary procedure. Mutually Exclusive edits check for procedures that represent overlapping services, or different techniques or approaches that accomplish the same result.

SECTION C: RESOLUTIONS

Once a claim has adjudicated, it is assigned one of four statuses by the OKMMIS system. The claim is paid, denied, suspended, or given a status of resubmit.

PAID CLAIMS

Paid claims are claims that contain services which are covered by Oklahoma SoonerCare; however, they do not always result in a payment being issued. For example, if a claim is submitted which has a primary insurance payment of $100.00, and a SoonerCare allowable of $75.00, the claim will be marked paid, since the charges are eligible for coverage. No payment would be made under this circumstance. Additionally, if any lines on the claim are covered, the claim will be marked paid, even though one or more of the service lines may have denied.

Once a claim is assigned a "paid" status, the payment will be issued on the following financial cycle (usually on Wednesdays),

and will be listed on the "Paid Claims" page of the provider's remittance advice (RA).

DENIED CLAIMS

Denied claims are claims that have been determined not covered by Oklahoma SoonerCare. These denials may be issued for various reasons including: non-covered services, inaccurate information submitted on the claim, member's eligibility or the provider's contract information.

Claims denied for non-covered service could be due to program restrictions or policy limitations that can be overridden with proper documentation. Providers can contact the OHCA call center for details on these denial types.

Claims denied for inaccurate information, including incorrect member's SoonerCare identification number, can be corrected by the provider and resubmitted for consideration.

Claims may be denied based on the member coverage being inactive for claim date(s) of service. Eligibility is determined by the Oklahoma Department of Human Services (OKDHS). Eligibility disputes should be directed to the member's local county OKDHS office.

In some instances, a claim may deny because of information listed on the provider's contract. The provider's contract period may have terminated or the provider's contract type may not be eligible to bill for the service provided (for example: a family practitioner billing for dental services).

SUSPENDED CLAIMS

Suspended claims are claims that are currently still in process. Claims suspend when they cannot be automatically adjudicated, or require additional review. Suspended claims are forwarded to a resolutions department for manual review. For example, if a claim has a primary insurance payment, the claim and attached documentation are reviewed. Remember, suspended claims are still being processed and do not need to be resubmitted.

RESUBMIT STATUS

Once a suspended claim has been reviewed, the resolutions department will resubmit the claim so the OKMMIS can rerun the editing process. The claims system cycles every six hours. Subsequently, a claim in resubmit status will normally adjudicate in no more than six hours. It is important to note that claims in resubmit status require no action from the provider.

WORKING DENIED CLAIMS

Claims can be denied at either the header or detail levels. The header level contains information about the member and provider, but not about the services performed. This is where the OKMMIS

will verify member's eligibility and provider's contract information. Denials at this level will cause the entire claim to be denied.

The detail level of the claim contains information specific to the services performed. The detail level verifies coverage of services, policy limitations or program restrictions. Denials at this level will deny specific service lines and not the entire claim.

Once a claim has been denied, providers have two ways to research their denials: via Medicaid on the Web or the RA.

RA Research

When researching using the RA, locate the denied claims section. Once you have found a denied claim, view the header information. Any edits applying to the header information will be listed as Header EOBs. These codes are the HIPAA Adjustment Codes and contain general information about the claim. For further description of these codes, see the EOB Code Descriptions page of the RA. You may find several edits listed. Please note that not all edits listed are denial edits. If there are no header denials, look at each detail line for edits specific to that service. These edits will be listed at the end of each detail line as Detail EOBs.

If the denial reason is still unclear, providers may contact the OHCA call center for assistance or log onto Medicaid on the Web at www.okhca.org and do additional research.

MOW Research

To research denied claims on Medicaid on the Web, go to the claim inquiry page. For information on how to get to this section, see the Web/RAS Usage chapter of this manual. On the claim inquiry screen, you may search by the denied ICN or the member ID and date of service. Once the claim has been accessed, scroll to the bottom of the claim to view the header and detail denials. The HIPAA Adjustment Code will be listed here along with a HIPAA Adjustment Remark Code, which provides more detailed information. If the denial reason is still unclear, you may click on the HIPAA Adjustment Code number to view the MMIS EOB description. The MMIS EOB provides the most detailed information about the denial.

Once the reason for the denial has been determined, any inaccurate or incomplete information can be corrected and the claim can be resubmitted for processing. If all information is accurate and complete, the claim may have denied due to policy limitations or program restrictions.

Chapter 9

Paid Claim Adjustment Procedures

INTRODUCTION

This section explains the business processes of how claim-specific adjustments and non-claim specific adjustments flow through the Oklahoma Medicaid Management Information System (OKMMIS). It is the responsibility of the adjustment department to process in a timely manner all claim-specific and non-claim-specific financial transactions. When a claim is adjusted, it is reprocessed as a new claim. When the adjustment claim processes, it may be affected by system changes made since the original claim was processed.

SECTION A: ADJUSTMENT CATEGORIES

Adjustments are classified in two categories – check-related (refund) or non-check related. Check-related adjustments are classified as either full or partial. An explanation of the claim adjustment types is provided below. Adjustments are made to paid detail lines only on paid claims.

NON-CHECK RELATED ADJUSTMENT

Underpayment Adjustment
The provider is seeking additional reimbursement for a paid claim. The net payment to the provider is the difference between the original claim amount and the adjusted claim amount, when the adjusted claim amount is more than the original claim amount.

Overpayment Full Offset
The provider or the OHCA has recognized that a full overpayment for a claim occurred, and the provider or the OHCA has requested that the overpayment amount be deducted from future claim payments to the provider. After the adjustment void processes, the claim is systematically adjusted to zero and an account receivable is established for the entire amount of the claim.

Overpayment Partial Offset
The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider has requested that the overpayment amount be deducted from future claim payments. The historical data for the claim are adjusted and an account receivable is established for the overpayment amount.

CHECK RELATED ADJUSTMENT

Full Claim Refund
The provider or the OHCA has recognized that a full overpayment for a claim occurred and the provider issues a refund check for the amount of the entire claim payment. During the claim adjustment process, the refund amount is applied to the claim and the original claim is systematically adjusted to zero.

Partial Claim Refund
The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider issues a refund check for the amount of the overpayment. The refund amount is applied to the adjustment claim during processing and the historical data for the claim are adjusted.

NEGATIVE ADJUSTMENT AMOUNTS (OVERPAYMENTS)

If a claim is incorrectly adjudicated and the provider receives an overpayment, the provider is required to immediately take action with one of the following options:

- Mail a check in the amount of the overpayment along with a completed adjustment request form (HCA-14 for UB-04, and IP/OP Crossover or HCA-15 for CMS 1500, Dental and Crossover Part B).
- Void the claim on the secure site (Medicaid on the Web) to setup a recoupment.
- Complete an adjustment request form (HCA-14 or HCA-15) and submit it according to the instructions on the form.

In addition, include: a copy of the paid remittance advice, and when applicable, a copy of the corrected claim; copy of the Medicare EOMB; and/or a copy of the insurance EOB.

Send to:

OHCA
Attention: Finance Division
PO Box 18299, Oklahoma City, OK 73154

If the payment is not received, recoupment procedures will be initiated by the OHCA.

When a claim recoupment procedure is initiated, an amount will be posted in parenthesis on the "Paid Amount" column on the adjustment RA. The recoupment

amount is subtracted from the provider's claim payment. If a negative balance is outstanding, it is carried forward as an outstanding recoupment amount and deducted from future claim payments. A summary of the recoupment activity is reported on the financial transactions page of the RA.

POSITIVE ADJUSTMENTS (UNDERPAYMENTS)

If a claim is incorrectly adjudicated and the provider receives an underpayment, the OHCA will initiate procedures to generate a payment adjustment to the submitted claim.

If the provider identifies an underpayment error to a paid claim, the provider may request a payment adjustment by submitting:

1. A completed adjustment request form (HCA-14 for UB, Inpatient/Outpatient crossover, or HCA-15 for 1500, Dental or Crossover Part B) for each claim requested for adjustment.
2. A copy of the paid RA or detailed explanation of the paid information and a copy of the corrected claim. If applicable, a copy of the Medicare EOMB and/or copy of the insurance EOB.
3. Any additional documentation – including sterilization consent form, the hysterectomy acknowledgment, abortion certification or patient certification for Medicaid funded abortion. These documents must be attached to the adjustment request in order to assist the OHCA in making proper determination

All documentation is mailed to:
OHCA
Attention: Adjustments
4545 N Lincoln Boulevard, Suite 124
Oklahoma City, OK 73105

OHCA Review

Each adjustment request is reviewed for proper documentation and OHCA policy and procedural compliance. Requests failing to meet these requirements will be returned to the provider for the missing information.

SECTION B: ADJUSTMENT TYPES AND WORKFLOW

Adjustments are typically initiated by the provider but may also be requested by the OHCA. The provider completes an adjustment request form and forwards it to the specified adjustment address on the form.

NON-CHECK-RELATED ADJUSTMENT (REGIONS 50 AND 56)

Non-check-related adjustments are defined as provider requests for additional payment, which are referred to as:
1. an underpayment adjustment, or
2. provider requests for an overpayment amount to be deducted from future claim payments (referred to as an offset adjustment).

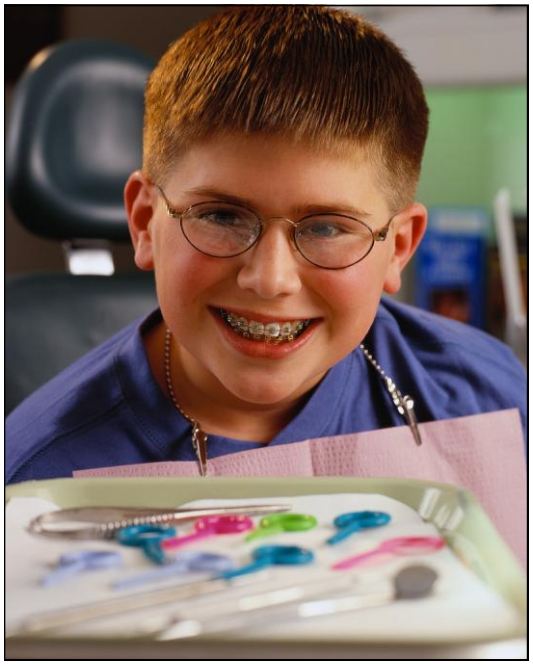
Offset adjustments are further categorized as full-claim offsets or partial-claim offsets. Non-check-related adjustments are processed through the OKMMIS.

CHECK-RELATED ADJUSTMENT (REGIONS 51 AND 57)

Check-related-adjustment requests are cash receipts received and dispositioned as claim-specific refunds to the OHCA. The refunded dollar amount is posted to the specific claim as the adjustment is processed in the OKMMIS. A reason code, that indicates the source of the refund, is typed in the adjustment record. This allows the system to categorize the refunds into provider, SURS and TPL recoveries for cash management reporting. Check related adjustments are processed through the OKMMIS.

Chapter 10

Indian Health Services



INTRODUCTION

In Oklahoma there are three types of Indian Health facilities: Indian Health Service (IHS), Tribes and Urban Indian clinics. IHS is the federal agency responsible for providing health services to most American Indians and Alaska natives. Unlike SoonerCare, IHS is not an entitlement program. Instead, this provision of health care to American Indians and Alaska natives falls under the federal trust responsibility that recognizes the debt owed to Indian tribal governments. Eligibility for care at IHS, Urban Indian and Tribal facilities is usually determined under federal statute and regulation, and depends largely (but not exclusively) on membership in a federally recognized tribe.

SECTION A: SOONERCARE ELIGIBILITY

As a matter of law, American Indians who meet SoonerCare eligibility standards are entitled to SoonerCare coverage. This applies to American Indians as it does to other American citizens. SoonerCare reimburses Indian Health providers for covered services provided to American Indian SoonerCare members. Indian Health is always the payer of last resort when an American Indian SoonerCare member is eligible for services through multiple payers such as Medicare, Medicaid and Indian Health.

SECTION B: CONTRACT HEALTH SERVICES

Most IHS, Tribal and Urban Indian facilities provide basic health care services. When specialty services are needed, an Indian Health facility may authorize payment for "contract health services." Contract health services are defined by IHS as "services not available directly from IHS or tribes that are purchased under contract from community hospitals and practitioners." It is important to note that contract health services are usually purchased through a prior authorization arrangement. Since Indian Health is not an insurance company, it is not obligated to pay for health care services unauthorized by the facility.

Specific Medicaid billing information for Indian Health providers is available in the SoonerCare Indian Health Billing Guide.

Chapter 11
Pharmacy

INTRODUCTION

The purpose of the pharmacy division is to manage the Medicaid Pharmacy program in the most efficient and comprehensive manner possible by researching, designing and implementing mechanisms to ensure appropriate, cost effective and quality therapy.

PHARMACY POLICY (RULES)

Here is a brief overview of Pharmacy rules*:

- Dispensing limitation: 34 day supply or if on maintenance list up to 100 units.
- Covered Drugs: Must have a Federal Drug Rebate Agreement.
- Excluded Categories: Fertility, cosmetic, weight loss/gain, nutritional supplements.
- Reimbursement - Use the lower of
  - federal upper limit on state maximum allowable cost;
  - EAC (AWP – 12%); or
  - Pharmacy's Usual & Customary Cost.
- Dispensing Fee – Up to $4.15.
- Copays:
  - $1 for ≤ $29.99; $2 for ≥ $30.
  - Copayment is not required of
    a. members younger than 21 years old;
    b. members in nursing facilities and intermediate care facilities for the mentally retarded; or
    c. pregnant women.
  - Copayment is not required for family planning services. Includes all contraceptives and services rendered.

*Pharmacy program rules change frequently. For the most up-to-date SoonerCare Pharmacy program rules, visit the OHCA Web site at http://www.okhca.org/provider/policy/pdflib/chapter30.pdf.

PRESCRIPTION DRUG BENEFIT

- Six Rxs per month with three brand name drug limit.
- Rxs that don't count toward perscription limit are HIV antiretrovirals, Chemo, contraceptives.
- Long Term Care – no limit.
- Members under 21 - no limit.
- Waiver Advantage members.
  - Seven extra generics plus Therapy Management, if more is needed.

PRODUCT BASED PRIOR AUTHORIZATION (PBPA)

This program divides certain therapeutic categories of drugs into two or more levels called "Tiers." Tier 1 medications are preferred

as the first step for treating a member's health condition. They are cost effective and in most cases available without prior authorization (PA) from the OHCA. Members who do not achieve a clinical success with Tier 1 medications may obtain a Tier 2 or greater medication with a PA. Providers that have members with clinical exceptions may request a PA to skip the step therapy process and immediately receive Tier 2 or greater. For more information, please review the OHCA Web site at http://www.okhca.org/providers/rx/pa

DURABLE MEDICAL EQUIPMENT (DME)

The general guidelines concerning the documentation necessary to obtain a prior authorization for DME supplies is located at http://www.okhca.org/providers/dme/paguidelines. Please be sure that you use your DME provider number, not your pharmacy provider number, when billing DME claims. DME claims will not process through the pharmacy point-of-sale system. For a list of providers that are willing to bill for DME supplies, go to http://www.okhca.org/providers/dme/dmeproviders. If you are not a contracted DME provider and would like to be, please contact provider contracts at 800-522-0114, opt. 5, or download, complete, and return the contract forms to http://www.okhca.org/providers/enrollment/dme-msc.

PHARMACY LOCK-IN PROGRAM

When it is decided that a member meets specific criteria and should be placed in the Lock-in program, a pharmacy is assigned to that member and their eligibility file is updated to only pay claims at that pharmacy. Referrals are made to the Lock-In unit by several sources. These include: physicians, pharmacies, caseworkers and OHCA staff. Referrals can be made by phone, online or in writing. Pharmacy help desk technicians review members' claims when assisting callers with claim problems and will turn in any suspicious activity.

Lock-In Decision Process

Once a member is referred to the Lock-in program, the following information is verified and reviewed for each case.

1. Eligibility (members that are not eligible or have Medicare are not reviewed).
2. Medicare eligibility.
3. Paid pharmacy claims for past year.
4. Hospital claims for past year.
5. Full history of diagnosis summary.
6. List of prescriber specialties.

The lock-in process is started if the member meets the required criteria based on this information.

Cases that look questionable but do not fully meet the criteria generally result in the monitoring of members or a warning letter sent to members. Warning letters are sent to members explaining that they are being monitored due to a high number of visits to different pharmacies. Cases that receive warnings are reviewed again in six months. If there is no improvement, the members are entered into the Lock-in program. If the behavior improves, the cases are closed. If a decision is made to monitor without a warning, the case is reviewed again in three months and a new decision is made based on behavior pattern.

OBNND's Web site reveals member who paid cash for Controlled substances

Safety Concerns Criteria List
Number of ER visits (3).
Number of different pharmacies (3).
Number of different prescribers/physicians (5) (combined).
Number of days supply of anxiolytics, antidepressants etc.
Diagnosis of drug dependency/ other diagnosis.
Number of hospital discharges (3).
Other information from past reviews.

Who To Call
-OHCA *Main number* - 800-522-0114 or 405-522-6205

-Pharmacy Help Desk, Opt 4 - Mon-Fri (8:30a – 7:00p), Saturday (9am-5pm) and Sunday (11am-5pm)

Chapter 12

Insure Oklahoma

INTRODUCTION

The Insure Oklahoma was founded in 2005 in an effort to help provide health coverage to uninsured and working Oklahomans.

Insure Oklahoma is a program under the SoonerCare umbrella and administered by the Oklahoma Health Care Authority (OHCA). This program consists of two benefits branches.

First is the Insure Oklahoma Employed Sponsored Insurance (ESI) program geared to small businesses. This program offers premium subsidy assistance for qualified group health care plans to eligible employees.

The second is Insure Oklahoma Individual Plan (IP), which is designed as an option for people who cannot access Insure Oklahoma through their employer.

Member eligibility for both programs requires candidates to:

- have a household income not exceeding 185 percent of the federal poverty level (FPL),
- have valid Oklahoma residency and U.S. citizenship,
- be a legal alien not currently receiving Medicaid or Medicare services, and
- be 19 to 64 years old.

SECTION A: WHAT IS THE INSURE OKLAHOMA INDIVIDUAL PLAN?

Insure Oklahoma is operated by the OHCA. An Insure Oklahoma Individual Plan member must choose an Insure Oklahoma provider for themselves, and if eligible, their spouse.

This plan provides coverage to eligible

- self-employed individuals;
- workers who cannot access Insure Oklahoma through their employer;
- workers who have a disability with a ticket to work receiving benefits from the Oklahoma Employment Security Commission (OESC); or
- unemployed individuals currently seeking work.

Questions about benefits or the plan in general should be directed from Monday through Friday, 7:30 a.m. to 5:30 p.m., to the Insure Oklahoma Helpline at 888-365-3752 or TDD at 405-416-6848.

PERSONS INELIGIBLE FOR THE INSURE OKLAHOMA INDIVIDUAL PLAN

Certain persons are ineligible for Insure Oklahoma even though they may be eligible under other portions of the SoonerCare program. These "Exempt" persons will not be enrolled in Insure

Oklahoma if they are: a dependent 18 years old or younger or eligible for Medicare or Medicaid, including SoonerCare Choice.

COVERAGE FOR CHILDREN

Children are not eligible for Insure Oklahoma, but may qualify for health care coverage through SoonerCare Choice. Call 405-521-3646 for more infomation.

MEDICAL ID CARD

Insure Oklahoma medical ID cards look different than SoonerCare cards. See example below:

IMPORTANT PHONE NUMBERS

Emergency Services

Call 911 or go to the nearest emergency room. Call your medical provider as soon as possible. Do not use the emergency room for urgent care. Urgent care is when you get sick or hurt and there is no immediate danger. Call your medical provider for urgent care.

Provider Eligibility

Only claims from OHCA-contracted providers will be considered for payment. This card does not guarantee eligibility or payment for services. To confirm eligibility, call the nationwide toll-free number at 800-767-3949 and in metro Oklahoma City at 405-840-0650 or access the secure Web site at: www.okhca.org.

All other provider inquiries, call the Insure Oklahoma Helpline at 888-365-3742.

Members

For general information, call the Insure Oklahoma Helpline at 888-365-3742. For TDD Line, call 405-416-6848. For the Patient Advice Line, call 800-530-3002.

SECTION B: INSURE OKLAHOMA INDIVIDUAL PLAN BILLING PROCEDURES

The billing procedures for the Insure Oklahoma IP are the same as the SoonerCare billing procedures. Please refer to the Claim Completion chapter of this manual for details. The Insure Oklahoma IP uses the same mailing addresses as SoonerCare.

Claims are subject to a co-payment. The provider reimbursement will be based on the Medicaid allowable plus the co-payment. Providers who choose to be primary care physicians will be assigned a panel. Primary care referrals will follow the same guidelines as they do with SoonerCare.

PCP PAYMENTS

Insure Oklahoma PCPs will get a $3 monthly case-management fee per recipient.

CHANGES TO PRIMARY CARE PHYSICIAN PANELS

If the provider's panel is closed, yet there is a patient the provider is willing to add to its panel, the appropriate form will need to be completed and faxed to 405-949-9563.

ELIGIBILITY

Checking eligibility for IP will follow the same process as SoonerCare. A magnetic strip on the back of the card is used by the swipe machines to read member information. Eligibility will also be accessible on the Web, through the Automated Voice Response (AVR) system and by contacting Customer Service at 888-365-3742. When viewing eligibility, the system will reflect the program for Public Product (PUB), for those enrolled in the IP.

PRIOR AUTHORIZATION

The OHCA handles the IP Prior Authorization (PA) process.

ADJUSTMENTS

Adjustments for the IP guidelines are the same as SoonerCare's.

Chapter 13

Long Term Care Nursing Facilities

INTRODUCTION

SoonerCare provides members with coverage for long-term care (LTC) nursing facilities and Intermediate Care Facilities for the mentally retarded (ICF-MR). SoonerCare reimburses providers with a set lump-sum payment for each member under their care. Items covered by the reimbursement include: dietary needs, room and board, personal hygiene items and most over-the-counter drugs.

SECTION A: LTC NURSING FACILITY PROVIDER ELIGIBILITY

Long-Term Care (LTC) Nursing Facilities may receive payment for the provision of nursing care under the SoonerCare Title XIX program only when they are properly licensed and certified by the Oklahoma Department of Health, meet federal and state requirements, and hold a valid written agreement with the Oklahoma Health Care Authority (OHCA).

To obtain additional information, go to http://www.okhca.org, click on the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and click on Chapter 30.

SECTION B: PRE-ADMISSION SCREENING AND RESIDENT REVIEW PROCESS (PASRR)

Federal law requires that all members entering SoonerCare certified nursing facilities must be screened for possible mental illness, mental retardation or related conditions prior to admission. Nursing facilities are required to complete form LTC-300A for all members entering the facility, regardless of pay source. For additional information, go to http://www.okhca.org, click on the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and click on Chapter 30.

SECTION C: ICF/MR PROCESS

Pre-approval and final approval for medical eligibility of SoonerCare certified members entering public and private ICF/MR are made by the Level of Care Evaluation Unit at the OHCA. ICF/MR facilities are required to complete form LTC-300 as well as provide evidence of mental retardation or related condition and additional documentation of active treatment needs. For additional information, go to http://www.okhca.org, click on the Provider

link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and click on Chapter 30.

SECTION D: MEMBER LEVEL OF CARE APPEALS PROCESS

By law, any member who feels adversely affected by any preadmission screening and resident review (PASRR) determination made by the OHCA regarding a preadmission screening or an annual resident review may request a fair hearing within 30 days from the date of notice of the PASRR result. The member or authorized agent may contact the county DHS office to request a fair hearing Form H-1 to initiate the appeals process.

Providers or physicians who would like to appeal a level-of-care decision may request the OHCA form LD-2 by contacting the OHCA Grievance Docket Clerk Legal Division at 405-522-7217

For additional information on documentation standards, go to http://www.okhca.org, click on the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and click on Chapter 30.

SECTION E: BILLING CONSIDERATIONS

Individuals requesting billing information regarding nursing facilities should refer to the Electronic Data Interchange and Billing Instructions chapters of this manual. Nursing facilities will use the UB 92 paper form, 837-I for electronic batch submission and/or Direct Data Entry through the OHCA secure Web site for claim submission. Verifying the member's eligibility and program eligibility is very important. Members in nursing facilities are excluded from enrollment in SoonerCare Choice. If a member is enrolled in SoonerCare Choice, they must be disenrolled from managed care after admission to a nursing facility or ICF-MR.

Chapter 14

Third Party Liability

INTRODUCTION

Private insurance coverage generally does not exclude an individual from receiving Oklahoma Health Care Authority (OHCA) benefits. Many OHCA members have other insurance in addition to the OHCA. Insurance may be a commercial group plan through the member's employer, an individually purchased plan, Medicare, or insurance available as a result of an accident or injury. For most Oklahoma members, the OHCA supplements other available coverages and is primarily responsible for paying the uncovered medical expenses.

To ensure that the OHCA does not pay expenses covered by other sources, federal regulation *(42 CFR 433.139)* established the OHCA as the payer of last resort. This means that if an OHCA member has any other resource available to help pay for the cost of his or her medical care, that resource must be used prior to the OHCA. Other resources include, but are not limited to

- commercial health insurance policies, both group and individual;
- Medicare;
- TRICARE, formerly known as CHAMPUS;
- indemnity policies that pay a fixed per diem for hospital or nursing home services;
- auto insurance;
- homeowner's insurance;
- worker's compensation; or
- other liability insurance.

In Oklahoma, the Victim Compensation Act and Indian Health Services are the only resources that do not have to be used prior to the OHCA.

OHCA THIRD PARTY LIABILITY PROGRAM

The OHCA Third Party Liability (TPL) program is charged with ensuring compliance with federal and state TPL regulations. The program has two primary responsibilities:

1. To identify OHCA members who have third party resources available.
2. To ensure that those resources pay prior to the OHCA.

The OHCA has full authority to fulfill these responsibilities. The OHCA member must sign an assignment of rights form, which allows the third party payment be made directly to the OHCA. This is one of the eligibility conditions to OHCA membership. Each member must further agree to cooperate with the OHCA to obtain payment from those resources, including authorization of providers and insurers to release necessary information to pursue third party

payment. TPL requirements are the same, regardless of the type of third party resource. The TPL program fulfills its responsibilities based on whether the other resource falls under the general category of health insurance. These may include: commercial policies, Medicare, and liability insurance such as auto and homeowner.

The TPL program has four primary sources of information for identifying members who have other health insurance: caseworkers, providers, data matches and discrepancy letters.

Caseworkers
When a member applies for SoonerCare, the caseworker asks if the member has other insurance coverage. If so, the caseworker obtains all available information about the other policy and updates the member's file, which will update the OKMMIS with that information.

Providers
During the OHCA member's medical appointment, providers must ask if the member has other insurance coverage. If so, the provider obtains information about the other policy and provides it to the OHCA by written notice, phone call or inclusion on a claim form. Providers should request that the OHCA member sign an assignment of benefits authorization form. This form should state that the member authorizes the insurance carrier to reimburse the provider directly.

Data matches
The OHCA uses private vendors, Health Management Systems (HMS) and Electronic Data Systems (EDS) to perform regular data matches between OHCA members and commercial insurance eligibility files. Data matches are performed with all major insurers, including Blue Cross and Blue Shield, Aetna, Cigna, HealthChoice and others.

Discrepancy Letter
The discrepancy letter is used to update the OHCA member’s file. This letter will be mailed to a provider when there is a TPL payment indicated on a paid claim, but no TPL is shown in the EDS system. The completed discrepancy letter can be faxed or mailed to the TPL unit. The unit verifies the information prior to updating the system. This form can be downloaded from the OHCA Web site. It is located in the Forms section under TPL forms. Regardless of the source, all TPL coverage information is stored in the EDS system and available to providers through the Eligibility Verification System (EVS).

SECTION A: SERVICES EXEMPT FROM THIRD PARTY

LIABILITY/ COST AVOIDANCE REQUIREMENTS

To increase overall savings to the OHCA, the Centers for Medicare and Medicaid Services (CMS) encourage three types of medical services:

1. Pregnancy care.
2. Prenatal care.
3. Preventive pediatric care, including Early Periodic Screening Diagnosis and Testing (EPSDT)

To help ensure that providers are not deterred from providing these services, federal regulations exempt claims for these types of care from the cost-avoidance requirement. Providers that render any of these exempted services are still permitted, but are not required, to bill available third party resources. Claims for these services, identified by the diagnosis codes, bypass the normal cost-avoidance process.

Cost Avoidance

When a provider determines that a member has an available TPL resource, the provider is required to bill that resource prior to billing the OHCA. If the EVS indicates TPL resource information and the provider submits a claim to the OHCA without documentation that the third party resource was billed, federal regulations (with a few exceptions as described in Section B of this chapter) require that the claim be denied. This process is known as "cost avoidance." When a claim is cost avoided, the provider must bill the appropriate third party. If that resource denies payment or pays less than the OHCA would have paid, the provider can rebill the OHCA. Providers must be fully aware of and comply with the procedures outlined in this chapter to prevent claims from being erroneously cost avoided.

Liability Insurance

Unlike health insurance, liability insurance is generally available only under certain circumstances. For example, an auto insurance liability policy covers medical expenses only if expenses are the direct result of an auto crash and the policy's insured is liable. However, if there is "medical payments" coverage under the auto policy of the vehicle in which the member was injured, the member must only establish that the injuries are accident-related. He or she does not have to establish liability to pursue a medical payments' claim. Under homeowner's and other property-based liability insurances, the at-fault party's liability generally must be established before an injured member is reimbursed for medical

expenses related to the injury, unless there is a separate medical payments coverage available under the policy. In that case, to obtain medical payment benefits, the member would typically only have to establish they were injured on the property. Because of the circumstantial nature of this coverage, the OHCA does not cost avoid claims based on liability insurance.

If a provider is aware that a member has been in an accident, the provider can bill the OHCA or pursue payment from the liable party. If the OHCA is billed, the provider must note that claims are for accident-related services by marking the appropriate box in field 10b on form 1500, listing the appropriate occurrence code on form UB-92; or entering the appropriate Related Causes Code in data element 1362 on form 837 Professional (837P) or 837 Institutional (837I) electronic transaction. Providers that choose to initially pursue payment from the liable third party must remember that claims submitted to the OHCA after the one-year timely filing limit are denied.

When the OHCA pays claims for accident-related services, the TPL program performs post-payment research, based on trauma diagnosis codes, to identify cases with potential liable third parties. When third parties are identified, the OHCA presents all paid claims associated with the accident to the responsible third party for reimbursement. Providers are not normally involved in this post-payment process, and are not usually aware that the OHCA has pursued recoveries. Providers may contact the TPL unit with questions about TPL case procedures and are encouraged to report all identified third party liability cases to the TPL unit. For example, if a provider receives a record's request from an attorney regarding a third party liability case, providers are encouraged to notify the TPL unit of these requests.

SECTION B: THIRD PARTY LIABILITY CLAIM PROCESSING REQUIREMENTS

This section outlines provider responsibilities for supporting cost containment through timely identification and billing of primary insurers. Providers are required to bill all other insurance carriers prior to billing the OHCA, except for programs that are secondary to the OHCA. The TPL Unit is available to assist with determining other insurance resources and maintaining the most current member TPL files.

DOCUMENTATION REQUIREMENTS

The OHCA must deny claims if there is evidence that TPL exists and documentation indicating that the third party was billed is not submitted with the claim. To prevent claims from being denied,

providers must be aware of responsibilities concerning third parties and comply with the procedures described in this chapter.

THIRD PARTY LIABILITY IDENTIFICATION

Prior to rendering a service, the provider must verify that the member is eligible. Use the EVS described in the Member Eligibility chapter of this manual to check eligibility status for all members. Additionally, the EVS should be used to verify TPL information so providers can determine if another insurer is liable for all or part of the bill. EVS has the member's most current TPL information, including, the insurance carrier, benefit coverage and policy numbers. In some cases, it is not possible to determine by the EVS if a specific service is covered. If a specific service does not appear to be covered by the stated TPL resource, providers must still bill that resource to receive a possible denial or payment. For example, some insurance carriers cover optical and vision services under a medical or major medical plan. Medical services that are covered by a primary insurer must be billed first to the primary insurer. If there is no other insurer indicated on the EVS and the member reports no additional coverage, bill the service to the OHCA as the primary payer.

When the EVS shows a member is a qualified Medicare beneficiary (QMB) only or a specified low income Medicare beneficiary (SLMB) only, the provider should contact Medicare to confirm medical coverage. Failure to confirm medical coverage with Medicare could result in claim denial because the Medicare benefits may have been discontinued or recently denied. The OHCA pays the Medicare premiums for SLMB only and QMB only members, but does not provide medical coverage. The coinsurance and deductible are covered for members with Medicare entitlement.

PRIOR AUTHORIZATION

A service requiring OHCA's prior authorization (PA) must be satisfied to receive payment from the OHCA, even if a third party paid a portion of the charge. The only exception is when the third party payer is Medicare Parts A or B and Medicare allows in whole or in part for the service.

BILLING PROCEDURES

When submitting all claims, the amount paid by a third party must be entered in the appropriate field on the claim form or electronic transaction, even if the payment amount is zero ($0).

If a third party payer made payment, an explanation of payment (EOP), explanation of benefits (EOB), or remittance advice (RA) is not required for electronically submitted claims.

When a member has other insurance and the primary insurer denies payment for any reason, a copy of the denial such as an EOP, EOB or RA must be attached to the OHCA claim or the claim will be denied.

If an EOP, EOB or RA cannot be obtained, attach to the claim a statement copy or correspondence from the third party carrier.

When billing the OHCA for the difference between the amount billed and the primary insurer's payment, the OHCA pays the provider the difference, up to the OHCA allowable charge. If the primary insurer payment is equal to or greater than the allowable charge, no payment is made by the OHCA. In this instance, the provider is not required to send the claim to the OHCA for processing. Providers cannot bill members for any balance.

NON-COVERED SERVICES OR LIFETIME MAXIMUM EXCEEDED

When a service that is repeatedly furnished to a member and repeatedly billed to the OHCA is not covered by the third party insurance policy, a provider can submit photocopies of the original denial for up to one year from the date of the original denial. The provider should write "Non-Covered Service" on the insurance denial when submitting copies for billing purposes. For example, if an insurer denies a claim for skilled nursing care because the policy limits are exhausted for the calendar year, that same denial could be used for subsequent skilled nursing care related claims for the duration of that calendar year. The denial reason must relate to the specific services and timeframes of the new claim.

SUBSEQUENT THIRD PARTY LIABILITY PAYMENT

TPL payments received by providers for claims paid by the OHCA cannot be used to supplement the OHCA allowable charges. If the OHCA paid the provider for services rendered and the provider subsequently receives payment from any other source for the same services, the OHCA payment must be refunded within 30 days. The refund should not exceed the OHCA payment to the provider. Checks must be made payable to the OHCA and mailed to:

The OHCA Finance Unit
PO Box 18299
Oklahoma City, OK 73154

REMITTANCE ADVICE INFORMATION

If a claim denies for TPL reasons, comprehensive TPL billing information about the member is provided on the paper RA. Electronic RAs identify this information with the adjustment reason and adjustment remark codes. If the provider has information that corrects or updates the TPL information provided on the RA, follow the procedures for updating TPL information.

For additional information, refer to the Member Third Party Liability Update Procedures section in this chapter.

INSURANCE CARRIER REIMBURSES OHCA MEMBER

Providers with proof that an OHCA member received reimbursement from an insurance carrier should follow these steps:

1. Contact the insurance carrier and advise them that payment was made to the member in error. Request that a correction and reimbursement be made to the provider.
2. If unsuccessful, the provider must bill the member for the services. In future visits with the OHCA member, the provider should request that the OHCA member sign an assignment of benefits authorization form. The form states the member authorizes the insurance carrier to reimburse the provider. This process might result in reimbursement to the provider.

SECTION C: COORDINATION WITH COMMERCIAL PLANS

Specific guidelines must be followed to receive payment from the OHCA when submitting claims for a member enrolled in private preferred provider organization (PPO) or private health maintenance organization (HMO) plans.

HMO BILLING OHCA

The OHCA reimburses providers for co-payments and services not covered by commercial plans incurred by OHCA members under a capped arrangement.

Co-payment Billing

In 2001, the OHCA implemented a procedure for providers to bill the OHCA for HMO co-pays on eligible Medicaid recipients enrolled in private health plans and Medicare Replacement HMOs.

The appropriate claim form (UB-04 or 1500) should be used. At the top of the claim form, print in large letters: “HMO co-pay.” Use the appropriate procedure code. However, box 28 and 30 on the 1500 and box 55 on the UB-04, provide only the desired co-pay reimbursement amount.

Only paper claims will be accepted for HMO co-pays and all other blocks on the UB-04 or 1500 should be completed according to your provider manual.

The claim forms should be mailed to EDS at P.O. Box 18500, Oklahoma City, OK 73154, and will be subject to all other applicable regulations. If you have any questions, please call the OHCA at 405-522-6205 or 800-522-0114.

Covered And Non-covered Services Billing

When billing for services not covered under the member's plan, the provider bills the OHCA and indicates carrier denied in the TPL amount on forms 1500 or 837P. The provider must attach a copy of the statement from the capped plan that indicates the service is not covered. The OHCA requires that a member follow the rules of his or her primary insurance carrier. Therefore, if the primary insurance carrier requires the member to be seen by in-network providers only or payment will be denied, the OHCA does not reimburse for claims denied by the primary carrier because the member received out-of–network services. However, if the primary carrier pays for out-of-network services at the same rate as in-network services or at a reduced rate, the provider may submit the bill to the OHCA. Also, if the primary insurance carrier pays for out-of-network services, but does not pay a particular bill in full due to a deductible or co-payment, the provider may still submit the bill to the OHCA. If no payment or a partial payment was made by the primary carrier, this should be indicated on the claim form, and documentation from the carrier noting the deductible or co-payment amount must be attached to the claim.

SECTION D: MEDICARE-OHCA RELATED REIMBURSEMENT

Many OHCA members are eligible for Medicaid and Medicare. These individuals are called dually eligible. According to TPL regulations, Medicare is treated just as any other available resource. Thus, when an OHCA member is also enrolled in Medicare, providers must bill Medicare prior to submitting a claim to the OHCA for reimbursement. For an OHCA provider to receive reimbursement from Medicare, the provider must be enrolled in the Medicare program. Providers can be enrolled in Medicare as participating or nonparticipating. Medicare participating providers receive payment directly from Medicare. Medicare benefits for nonparticipating providers are paid directly to the OHCA member.

In either scenario, the OHCA pays the co-insurance and deductibles. If a provider is not enrolled in Medicare, either as participating or nonparticipating, the member should be referred to a Medicare/Medicaid dually enrolled provider. OHCA reimbursement is not available to a non-Medicare enrolled OHCA provider who renders service to a Medicare/Medicaid dually eligible member.

MEDICARE ENROLLED PARTICIPATING PROVIDER REIMBURSEMENT PROCESS

When a provider is enrolled with Medicare, the Medicare payment is made directly to the provider. The provider accepts Medicare's allowable amount and the patient is not responsible for the

disallowed amount. The OHCA is only responsible for the deductible and coinsurance. For example, the charge is $150, the allowable amount is $100, $50 is disallowed, the deductible is $25 and coinsurance is $15. Medicare pays $60; the provider absorbs $50. The OHCA pays $40. The member is not responsible for any charges

MEDICARE ENROLLED NON-PARTICIPATING PROVIDER REIMBURSEMENT PROCESS

When a nonparticipating provider is enrolled with Medicare, the Medicare payment is made to the member. The member is responsible for the complete charge, as the provider does not accept assignment. For example, the charge is $150, the allowable amount is $100, the disallowed amount is $50, the deductible is $25 and the coinsurance is $15. The patient is billed for $150. Medicare reimburses the patient $60 and the patient is responsible for paying the remaining $50.

The OHCA SoonerCare member must be referred to a Medicare/OHCA SoonerCare provider to receive the best benefit.

CROSSOVER CLAIMS

It is important to remember that providers must include the correct Medicare identification number for a claim to crossover automatically. The following information concerns crossover claims:

- If a provider does not receive the OHCA payment within 60 days of the Medicare payment, claims that did not crossover should be submitted to the crossover processing address.
- If the member has a Medicare supplement policy, proof of filing with the Medicare supplement carrier as well as Medicare must be submitted with the OHCA claim or the claim will deny.
- If the member has a Medicare supplement policy, the claim is filed with Medicare and automatically crosses over to the Medicare supplement carrier rather than the OHCA for payment of coinsurance and deductible. After the provider receives all EOBs, the provider must submit the claim and EOBs on paper to the OHCA.

NOTE*: If the TPL benefit code has been entered incorrectly as a hospitalization (A) or medical (C) versus Medicare Supplemental Part A (O) or Medicare Supplemental Part B (P) for the supplemental policy, the claim crosses directly to the OHCA and may be paid without proof of filing with the Medicare supplement carrier. These situations generally result in OHCA overpayments that must be refunded immediately. To prevent overpayment, a provider*

that identifies enrollees with a Medicare supplemental policy conveyed as an A or B on EVS can request a TPL file update by sending a copy of the enrollee's Medicare supplemental insurance card to the TPL Unit.

Providers whose claims are not crossing over automatically should contact Provider Enrollment to verify that OHCA has your Medicare provider number correctly in the system.

PRIOR AUTHORIZATION

Prior authorization is not required for members with Medicare Part A and Part B coverage if the services are covered by Medicare and Medicare pays for the services in whole or in part. Services not covered by Medicare are subject to normal prior OHCA authorization requirement restrictions, referral and prior authorization requirements of SoonerCare.

MEDICARE NON-COVERED SERVICES

Claims for services not covered by Medicare must be submitted to the OHCA's regular claims processing address, with a copy of the Medicare RA attached. These claims are treated as any other TPL claim. Certain services are excluded and never covered by Medicare; therefore, the OHCA can be billed first for these services, bypassing the requirement to bill Medicare first. This applies to Medicare supplements as well. Otherwise, OHCA benefits can only be paid to the provider of services after Medicare payment or denial of payment occurs.

OTHER THIRD PARTY LIABILITY RESOURCES

If the member has other insurance on file that covers those services not covered by Medicare, the other insurance resources must be billed before the OHCA.

SECTION E: MEMBER THIRD PARTY LIABILITY UPDATE PROCEDURES

Other insurance information is entered into the DHS system by the caseworker when a member is enrolled in the OHCA. The information is transmitted electronically via real-time transaction to the OHCA. The county office and the OHCA TPL Unit update TPL information. The TPL Unit is the primary entity for maintaining TPL information about the member. Providers who receive information about OHCA members from insurance carriers that is different from what is listed on EVS can forward the information to the TPL Unit. Information about additional insurance coverage or changes in insurance coverage must be relayed to the TPL Unit as soon as possible to keep member files current and to assist in accurate provider claim processing.

AUTOMATED RECOVERY, RESOURCE DATA REQUEST LETTERS AND QUESTIONNAIRES

Automated discrepancy letters and questionnaires are sent to insurance carriers, members, and providers when recoveries are initiated or TPL resource data are requested. When the TPL data are verified, the system is updated accordingly. As a result, providers have access to the most current insurance billing information through the eligibility verification system (EVS) applications or the automated voice response (AVR) system. When a discrepency letter is received, providers must thoroughly complete the form and return it to the TPL Unit via fax or mail. The address is indicated on the form.

Providers may access and use the discrepency letter, and TPL Accident/Injury Questionnaire on the OHCA Web site. When a questionnaire is completed, the provider can fax or mail it to the EDS TPL Unit. The TPL Unit verifies and investigates the information prior to updating the system.

GENERAL UPDATE PROCEDURES

When forwarding update information to the TPL Unit, indicate the member identification (RID) number and any other pertinent member or carrier data on all correspondence. Copies of letters, RA, EOB or EOP information from other insurance carriers are important for maintaining member TPL file information. Carrier letters, RAs, EOPs or EOBs that document coverage must substantiate any requested changes**.** Mail the above information concerning other insurance coverage to:

TPL Unit
Third Party Liability Update
4545 N. Lincoln Blvd., Ste 124
Oklahoma City, OK 73105

The TPL discrepancy letter can be downloaded from the OHCA Web site. When completed, providers should fax or mail it to the address indicated on the letter.

The TPL Unit can be reached by phone at 800-522-0114 and selecting option 3 then 2.

The TPL Unit reviews and verifies the OHCA member insurance information, coordinates with the carrier, if required, and makes necessary changes to the TPL file in the OHCA system to accurately reflect member TPL coverage. Providers can confirm the update with EVS or by calling the TPL Unit. Allow 10 business days from the date of receipt for the OHCA member's file to be updated.

TELEPHONE INQUIRY PROCEDURES

To discuss other insurance issues, providers should contact the TPL Unit using the telephone numbers below from 8 a.m. to 5 p.m. Monday through Friday, excluding holidays:

Third Party Liability Unit
800-522-0114, option 3 and 2
Fax: 405-530-3478

When calling the TPL Unit, have the member's identification number available. This telephone inquiry function is limited to TPL issues. Direct general provider inquiries to the OHCA Call Center.

NOTE: *OHCA cannot provide information about benefits covered under each coverage type. Providers should contact the insurance carrier for this information.*

WRITTEN INQUIRY PROCEDURES

Documentation must substantiate each change made to a member's TPL file. If changes to member files are necessary, providers must forward copies of information from other insurers that document the member's TPL information to be updated.

When forwarding update information to the TPL Unit, indicate the member's name; RID number; copy of EOB, RA, member's third party insurance card, letter from carrier and any other correspondence that will help maintain the member's TPL file. The TPL Unit verifies all TPL information submitted with the respective insurance carrier. Mail information about other insurance coverage to:

OHCA TPL Unit
4545 N. Lincoln Blvd., Ste 124
Oklahoma City, OK 73105
Third Party Liability Update

SUMMARY

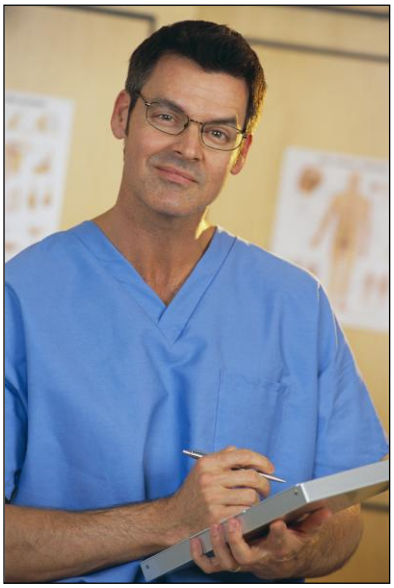
The following is a summary of the steps used to revise member TPL:

- When a policy is terminated, a patient was never covered, or the insurance carrier has a different billing address than on the TPL resource file, the provider sends the updated TPL information to the TPL Unit.
- If the provider sends documentation from the insurance carrier, the member's TPL file is updated with the corrected information within 10 business days from the date of receipt by the OHCA.

- If the provider sends in documentation that is not from the insurance carrier (discrepancy letter, copy of insurance card, handwritten note, etc.), the TPL unit will contact the insurance carrier to verify the other insurance information and if appropriate, update the system within 10 business days of receipt.
- The provider does not need to delay filing a claim; however, notifying the TPL Unit of updated TPL data will make subsequent billing easier.
- The provider can download the TPL questionnaire and discrepancy letter form from the OHCA Web site.

Do not send TPL-related claims to the TPL unit for processing.

Chapter 15
Prior Authorization



INTRODUCTION

Under the Oklahoma SoonerCare program, there are services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). To obtain additional information on PAs and a list of services that require PA, go to the OHCA Web site at www.okhca.org.

All services requiring PA will be authorized on the basis of the service procedure code. The OHCA authorization file will reflect the service codes authorized. A PA number will be assigned and a notice generated to the medical provider. The notice of authorization will contain the PA number, the service/procedure code authorized and the number of units. Notices will be provided online for providers using Web services or by mail for all other providers.

SECTION A: PRIOR AUTHORIZATION REQUESTS

MEDICAL AND DME REQUESTS

Requests for PA can be submitted by paper, fax or online. All prior authorization of medical or DME services must be submitted on form HCA-12A, the Oklahoma Prior Authorization Request form, and must include an HCA-13A cover sheet for each request.

Requests can be mailed or faxed to:

HP Prior Authorizations
2401 NW 23rd Street, Suite 11
Oklahoma City, OK, 73107
Local: 405-702-9080 or statewide toll-free: 866-574-4991

Online requests for PA are done by visiting the OHCA's secure site found at www.okhca.org

If a request for prior authorization of medical services is submitted electronically, any documentation including forms HCA-12A and HCA-13A are still required for medical review and must be submitted to the above address or fax number. Make sure the PA number assigned through the secure Web site is written in the designated field of the HCA13A.

DENTAL REQUESTS

Submit paper requests for PA of dental services on the current American Dental Association (ADA) claim form. Requests for routine procedures require mounted right and left bitewings (or a panoramic x-ray) and periapical x-ray. All orthodontic requests (comprehensive and minor) require submission of study models and a panoramic x-ray. Comprehensive orthodontic requests

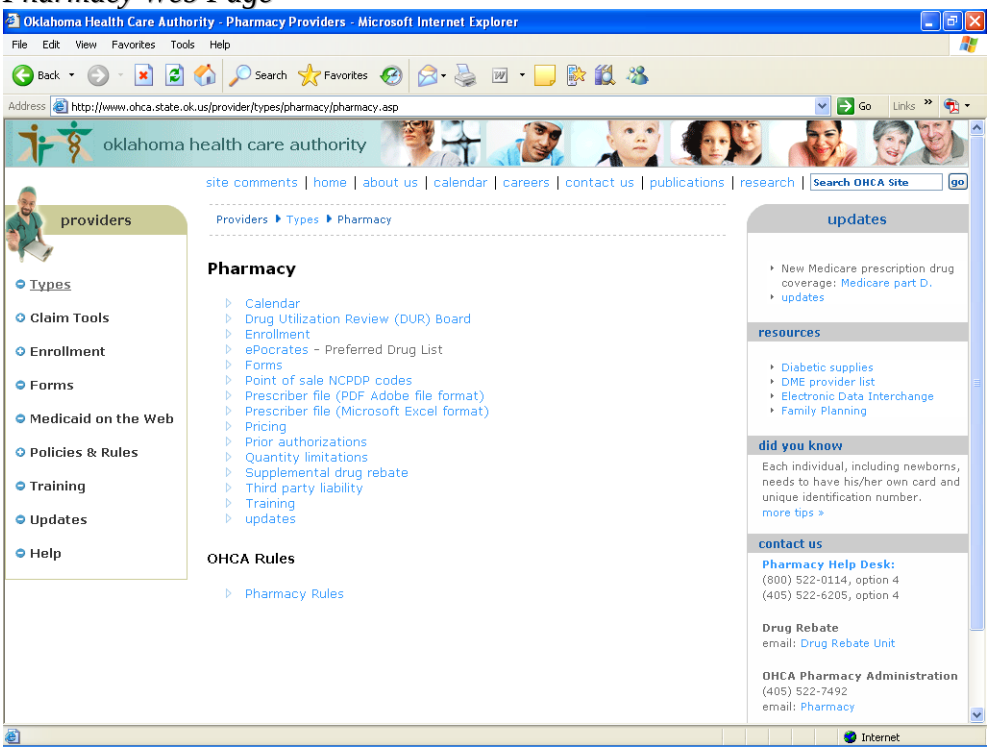
require a completed Index of Malocclusion form in addition to the ADA claim form. Diagnostic photographs may be submitted in place of study models. This is encouraged if at all possible. Submit paperwork, model and X-ray together. **DO NOT MAIL SEPARATELY**. These requests should be sent to:

OHCA Dental Authorization
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK, 73105

PHARMACY REQUESTS

Requests for PA for prescription medication should be submitted on the appropriate pharmacy PA forms. These forms are available on the OHCA Web site at www.okhca.org. The University of Oklahoma's College of Pharmacy, Medication Coverage Authorization Unit (MCAU), approves or disapproves each medication authorization request on behalf of the OHCA. The MCAU staff can be reached by phone at 405-522-6205 option 4 / 800-522-0114 option 4 or by fax at 405-271-4014 / 800-224-4014.

Pharmacy Web Page



Screen Sample 15.1

OUTPATIENT REHABILITATIVE BEHAVIORAL HEALTH, CASE MANAGEMENT, AND PSYCHOLOGIST SERVICES

Prior authorization request for outpatient rehabilitative behavioral health, case management, and/or psychologist services must be submitted using the outpatient request for prior authorization form.

This form is available on the APS Healthcare Web site at www.apshealthcare.com. The APS Healthcare Unit approves or disapproves these requests and may be reached by phone at 405-521-9700 or on the Web at www.soonerpro.com. Please submit PA requests with all supporting documentation to:

APS Health Care Midwest
4545 N. Lincoln Blvd., Suite 103
Oklahoma City, OK 73105

INPATIENT BEHAVIORAL HEALTH, DETOXIFICATION, GROUP HOME AND THERAPEUTIC FOSTER CARE SERVICES

Requests for PA of inpatient psychiatric services including acute and residential levels of care, detoxification, group home and therapeutic foster care for Medicaid members younger than 21 years old should be made by calling APS Healthcare. Instructions for this process are found on the APS Healthcare Web site at www.apshealthcare.com. The APS Healthcare Medicaid Preauthorization Unit approves or disapproves these requests and may be reached by phone at 800-762-1639. Behavioral Health Services does not require a referral from a SoonerCare member's PCP/CM.

If a behavioral health PA decision is in dispute, request a review from APS Healthcare by phone or a letter to the APS Health Care Midwest address above.

REQUESTS FOR SERVICES TO ILLEGAL/INELIGIBLE ALIENS

Illegal aliens are only eligible for emergency medical services. Requests for alien services should be submitted to the local county OKDHS office with a "notification of needed medical services" form, along with the history/physical and discharge summary. The county OKDHS office staff will complete the appropriate paperwork and forward all information to the OHCA's Provider Services Unit. Requests for emergency medical services to illegal aliens cannot be submitted online. The OHCA Medical Directors Unit approves or disapproves each medical service. If a disability or incapacity determination is required, the OHCA Provider Services Unit will coordinate that decision with the OHCA Level of Care Evaluation Unit (LOCEU). The OHCA Provider Services staff will notify the county OKDHS office of the decision(s) (the approval or denial) of the requested services. The OKDHS county office staff members are responsible for notifying the applicant and the provider of the decision.

SECTION B: PRIOR AUTHORIZATION PROCESS

The OHCA staff will issue either an approval or disapproval for each requested medical/dental service requiring a PA. A computer-

generated PA request decision form showing approval or denial of the service is mailed to the member. The request decision form is not a confirmation of the individual's eligibility for SoonerCare, and the approved clinical period for services may extend beyond the actual period of the member's eligibility. The request decision form serves as notification of the status of a request for PA or a notice of change for the listed services.

Prior authorization represents a clinical decision regarding medical necessity, but is not a guarantee of member eligibility or SoonerCare payment. It is the responsibility of the provider to verify not only SoonerCare eligibility, but also to verify program eligibility and benefit plan (for example: SoonerCare Choice, SoonerCare Traditional) at the time of service. Factors that affect payment are correct claim completion, appropriate referral (if required), provider contract, timely filing and member eligibility.

RETROACTIVE AUTHORIZATION

Medical Authorization should be requested prior to providing a service. If this is not possible due to urgent or emergency situations, the provider must request authorization within 30 days of the initial date of service. Requests received after 30 days of initial date of service will not be processed. The following conditions must be met for a retroactive medical authorization request to be approved:

1. The services rendered must be covered under the SoonerCare program.
2. The services must be verifiable and medical necessity must be documented.

See the Forms chapter of this manual for an example of the Medical and Dental Prior Authorization request forms.

SECTION C: RECONSIDERATION AND APPEAL PROCEDURES

LEVEL 1 – RECONSIDERATION

All denial reconsiderations for medical/DME must be submitted as a new authorization request. The same 30-day retroactive authorization limit applies to all reconsideration requests (i.e. the resubmitted request must be received within 30 days of the initial date of service).

Requesting a Reconsideration on an Authorization Decision

If there is reason to disagree with a medical/DME, dental, pharmacy or behavioral health prior authorization decision, mail or fax a letter and additional documentation requesting a review to the appropriate address below:

Medical:
HP Medical Authorizations
2401 NW 23rd Street, Suite 11
Oklahoma City, OK, 73107
Fax: Local 405-702-9080 or statewide toll free 866-574-4991

Dental:
Dental Medical Authorizations
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Pharmacy:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Medication Coverage Authorization Unit
P.O. Box 26901
ORI W-4403
Oklahoma City, OK 73190

Behavioral health:
Behavioral Health
APS Healthcare Behavioral Health Unit
4545 N. Lincoln, Suite 124
Oklahoma City, OK 73105

LEVEL 2 – APPEAL

Dissatisfaction with the results of a review may be disputed through formal appeal by returning a completed OHCA LD-2 Form to the OHCA Legal Division within 20 days of "Notice of Prior Authorization" recipient. Individuals may represent themselves, have another party represent them or have an attorney represent them. An LD-2 form may be obtained from the OHCA Web site at www.okhca.org, by contacting the Legal Division of the OHCA at 405-522-7217 or by sending a request to:

OHCA Legal Division Docket Clerk
P.O. Box 18497
Oklahoma City, OK, 73154-0497

In the appeal explain what's being appealed and the reason(s) for the appeal.

SECTION D: HOME & COMMUNITY-BASED SERVICES (HCBS) §1915(C) WAIVER PRIOR AUTHORIZATIONS

Medicaid State Plan services are provided to waiver members. Services that are covered as an integral part of the specific waivers must be prior authorized by the entity or agency that administers the particular waiver under which the member receives services.

ADvantage Waiver:
Long Term Care Authority
918-583-3336
www.ltca.org
Community Waiver, In-Home Supports Waiver for Adults, In-Home Supports Waiver for Children and the Homeward Bound Waiver:

OKDHS/Developmental Disabilities Services Division (DDSD)
405-521-6267
http://www.okdhs.org/programsandservices/dd/

Personal Care Services:
OKDHS – Personal care services are prior authorized by the OKDHS. Inquiries should be directed to the OKDHS county office in the county where the member resides and/or The Long Term Care Authority.

Chapter 16

Financial Services

INTRODUCTION

Financial Services ensure that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied correctly. The financial processing function includes generation of payments to providers and production of a remittance advice (RA) for providers that claims were adjudicated and/or financial transactions were processed. Payments are issued via electronic funds transfer (EFT). The only exceptions are: personal care, individual rehab, aides, respite care and foster care.

The Financial Processing function maintains the following information:

- Payment information (checks and EFTs).
- RA reporting.
- 1099 and W-2 IRS reporting.
- Void, stop payments, re-issuance of payments.

SECTION A: PAYMENT INFORMATION

PAYMENTS

The provider has two primary methods of receiving payment from SoonerCare: system-generated check and EFT. These payments, along with the RA, are produced during the financial cycle. The RA, which details each provider's claims and financial transaction activity during the period, is made available to the billing provider through paper or electronic formats to allow verification of billing and payments.

Checks or EFT notices are printed and enclosed with the RA for each provider that chooses to receive a paper RA and for each payment due. For those providers choosing to receive their RA electronically, the payment (check or EFT notice) is sent/mailed separately from the electronic RA.

Electronic Funds Transfers

Providers use the EFT payment option to expedite funds directly to their designated bank account. EFTs will be the default payment disbursement option for all providers unless it is proven that a provider cannot receive an EFT transaction. Those who cannot receive an EFT will receive their payment by paper check.

Manual Payments
A less common method for provider payment receipt is the paper warrant issuance (check).

State Agency Funds Transfers
For all state agencies participating in the Oklahoma Medicaid program, payments will be disbursed via state agency funds transfers. Since the Oklahoma Medicaid program is operated by a state agency, the funds are transferred to the corresponding state agency participating in the Oklahoma Medicaid program.

SECTION B: PAPER RA

OHCA providers receive a weekly RA for any claims submitted the previous week. The RA identifies claims that have been paid, denied, in process or adjusted. The RA includes the client ID number, the provider number, the Internal Control Number (ICN) of the claim processed, the date(s) of service and paid amount. The RA also details any reductions to the paid amount, for reasons such as TPL and/or client co-payment. Each claim detail might have an explanation of benefit (EOB) code explaining the reason for payment, denial, adjustment or in-process statuses. RAs are tailored to individual claim form types (for example: 1500, UB-04, Dental, and Pharmacy) and where appropriate, include additional information like procedure code, revenue code or admission and discharge date for providers that bill on the UB-04 claim form.

The RA has several document types in this order:

1 Check or EFT advice (if applicable)
2 Address page
3 Banner messages (if applicable)
4 Claims activity/status reports (if applicable)
   a Ordered by claim type (Physician, Institutional, Dental, Pharmacy)
   b Ordered by claim status (paid, denied, in process, adjusted)
5 Financial transactions
   a Expenditures (system generated only)
   b Cash receipts
   c Accounts receivable
6 TPL information (if applicable)
7 EOB descriptions (if applicable)

8 Summary report

Providers may request either an electronic or paper RA. The RA is generated in each claims payment cycle. A provider will receive an RA if the provider has activity during the claim cycle or outstanding accounts receivable.

REMITTANCE ADVICE SECTION DESCRIPTIONS

The RA contains the following information:

Medicare Crossover Paid

Claims with a paid status are shown in this RA series, including claims paid at zero.

Medicare Crossover Denied

These claims have been denied payment.

Medicare Crossover In Process

Claims in the processing cycle not finalized are listed in this RA series. Claims found here include

- with attachments;
- past the filing limit;
- suspended;
- requiring manual pricing; and
- with adjustments that have not been finalized.

These claims have not been denied. Claims reflected as "In Process" are ultimately shown as paid, denied or adjusted on subsequent RAs. Claims in process must be monitored to final resolution.

Claims Paid

Claims with a paid status are shown in this RA series, including claims paid at zero.

Claims Denied

These claims have been denied payment.

Claims in Process

Claims in the processing cycle that have not been finalized are listed in this RA series. Claims found here include

- with attachments;
- past the filing limit;
- suspended;
- requiring manual pricing; and
- with adjustments that have not been finalized.

These claims have not been denied. Claims reflected as In Process are ultimately shown as paid, denied, or adjusted on

subsequent RAs. Claims in process must be monitored to final resolution.

NOTE*: Each claim in process lists the EOB message that corresponds to the reason it has been suspended.*

Claim Adjustments
Adjusted claims are listed in this RA series. Two header lines are shown for each adjusted claim. The first header line is for the original or *mother* claim, while the second header line is for the adjusted or *daughter* claim.

Financial Transactions
Non-claim-specific payouts, refunds, and accounts receivable (A/R) transactions are listed in this series of the RA. A transaction number is used to uniquely identify each financial transaction. If a financial transaction is associated to a cash receipt, the cash control number (CCN) is also displayed for informational purposes. Examples of miscellaneous financial transactions tabulated in this RA section include

1. non claims specific payouts to a provider;
2. refunds made to the OHCA by a provider not associated with a single claim; and
3. amounts scheduled for recoupment, which the A/R section tracks repayment of to determine amount to be recouped.

EOB Code Descriptions
Explanation of Benefits (EOB) codes applied to submitted claims are listed along with the respective code narrative. These codes and corresponding narratives describe the reasons submitted claims were suspended, denied or not paid in full.

Summary
Data from the entire RA series are reflected on this page. This section summarizes all claim and financial activity for each weekly cycle and reports year-to-date totals.

REMITTANCE ADVICE SORTING SEQUENCE

Claims are shown on the RA by type and according to the following priority sequence:

1500
1. Alphabetically by member name.
2. Alphanumerically by patient number assigned by the provider.
3. Numerically by ICN.

UB-04
1. Alphabetically by member name.

2. Alphanumerically by patient number assigned by the provider.
3. Numerically by ICN.

Drug

1. Alphanumerically by prescription number.
2. Alphabetically by member name.
3. Numerically by ICN.

Dental

1. Alphabetically by member name.
2. Numerically by ICN.

EOB CODES

EOB codes are provided with each RA. These codes and the corresponding details describe the reason submitted claims were suspended, denied, or not paid in full. Because the claim can have edits and audits at both the header and detail levels, EOB codes are listed for both header and detail information. A maximum of 20 EOBs are listed for the header, and a maximum of 20 EOBs are listed for each detail line. Exceptions are suspended claims, which have a maximum of two EOBs per header and detail. **These are not denial codes, but rather the reason the claim is being reviewed.** EOB data are listed immediately following the claim header and detail information beside the caption of the EOB. EOB 00 lists header codes, EOB 01 lists line one of the claim's codes, and EOB 02 lists line two of the claim's codes. If there are no EOBs posted for a particular EOB XX line, the line is not printed. Explanation of benefits and denial information are provided in HIPAA compliant formats.

For more detailed EOB and denial information, providers are encouraged to use the OHCA secure Internet site available at www.okhca.org. Once there, use the claim inquiry option. An additional resource for this information can be found by calling 800-522-0114 and selecting option 1, for claim status.

For more information about HIPAA, please visit: http://www.cms.hhs.gov/

For a detailed listing of these new HIPAA codes, visit:

http://www.wpc-edi.com/ClaimAdjustment_40.asp.

REMITTANCE ADVICE EXAMPLES

The following pages display examples of the OHCA RA and detailed information regarding the statements. The illustrative samples give examples of where the data are found on the RA document. Examples that follow the illustrative samples

include claims adjudication pages for each claim type. The examples are a representative sample of what a provider might see on an RA. This is not a comprehensive listing for each claim type.

REPORT: CRA-0006-W
PROCESSS: FNI03011
LOCATION: FINJW201

STATE OF OKLAHOMA
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500**(a)** CLAIMS PAID**(b)**

DATE: 02/25/2004
PAGE: 1

HOLIDAY, KASON
1515 NORTH STREET**(f)**
OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted and Recouped

PAYEE NUMBER 123456789 A**(c)**
PAYMENT NUMBER 333222000**(d)**
ISSUE DATE 02/25/2004**(e)**

--ICN--	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	REIMB. AMOUNT	PAID AMOUNT
CLIENT NAME: MARY ZEPHEREZ				CLIENT NO.: 222555888					
2204365123456	020404	020404	150.00		0.00		0.00		150.00
				150.00		0.00		150.00	

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	SERVICE DATES THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
11	90801		1.00	020404	020404	212345678	150.00	150.00	A2

(a) Claim types are separated by pages and are indicated in the title: CMS-1500, inpatient, outpatient, Part B Medicare Crossovers, Part A Medicare Crossovers, Dental, and Drug

(b) Each page has a title: Paid, Denied, In-Process, and Adjustments

(c) Payee Number is the billing provider's Medicaid number and service location code

(d) Payment Number is the warrant (check) number

(e) Issue Date is the effective date of the Electronic Funds Transfer or the date printed on a paper check

(f) Address is the "Pay To" provider address

REPORT: CRA-0116-
PROCESS: FNIO3011
LOCATION:FINJW201

STATE OF OKLAHOMA
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIM ADJUSTMENTS

DATE: 02/25/2004
PAGE: 2

HOLIDAY, KASON
1515 NORTH STREET
OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted and Recouped

PAYEE NUMBER 123456789 A
PAYMENT NUMBER 333222000
ISSUE DATE 02/25/2004

--ICN-- / --PATIENT NUMBER	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	REIMB. AMOUNT	PAID AMOUNT
CLIENT NAME: MARY ZEPHEREZ CLIENT NO.: 222555888									
2204365123456**(a)**	020204	020204	(150.00)		0.00		0.00		(150.00) **(b)**
1330699				(150.00)		0.00		(150.00)	
5204365002099**(c)**	020204	020204	125.00		0.00		0.00		125.00**(d)**
1330699				125.00		0.00		125.00	

HEADER EOBS: 129

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
11	90806		1.00	020204	020204	123456788	125.00	125.00	100 A2

NET OVERPAYMENT (AR) 25.00**(e)**

(a) Original or active claim appears first and is reversed with negative dollar amounts **(1.1.)**

(b) Claim is reprocessed and given a 50 series ICN beneath the original or active claim

(c) 50 series ICN is now the current active claim

(d) New ICN processes for payment or denial

- If the new claim process for additional payment, the difference between the original payment and the new payment will result in an additional payment

(e) If the new claim process for less then the original claim, the difference becomes an Accounts Receivable

REPORT: CRA-0000-W STATE OF OKLAHOMA DATE: 02/25/2004

PROCESS: FNIO3011 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 3
LOCATION:FINJW201 PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

HOLIDAY, KASON
1515 NORTH STREET
OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted and Recouped

PAYEE NUMBER 123456789
PAYMENT NUMBER 333222000
ISSUE DATE 02/25/2004

----------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS(**a**)----------

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	RENDERING PROVIDER	SVC DATE FROM	SVC DATE THRU	CLIENT NO.	CLIENT NAME

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

----------NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS(**b**)----------

--CCN--	REFUND --AMOUNT--	REASON CODE	CLIENT NO.	CLIENT NAME

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

----------ACCOUNTS RECEIVABLE(**c**)----------

A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL --AMOUNT--	TOTAL -RECOUPED-	--BALANCE--	REASON CODE
5204365002099	021804	25.00	25.00	25.00	0.00	8400

(a) Non-Claim Specific Payout to Providers: Disproportionate Share Payments (Hospitals)
(b) Non-Claim Specific Refunds From the Providers: Provider submits a check that goes against an Accounts Receivable not associated with a claim
(c) Accounts Receivable

- A/R number is the Adjustment ICN if the Accounts Receivable is claim related
- Recouped this Cycle: Amount subtracted from current warrant amount and decreased the amount of AR.
- Original Amount: The dollar amount at the time the Accounts Receivable was set up
- Total Recouped: How much has been satisfied to date
- If a balance remains, the Accounts Receivable will carry over to the next weeks RA

REPORT: CRA-0148-W
PROCESSS: FNI03011
LOCATION: FINJW201

STATE OF OKLAHOMA
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 02/25/2004
PAGE: 4

HOLIDAY, KASON
1515 NORTH STREET
OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted and Recouped

PAYEE NUMBER 123456789 A
PAYMENT NUMBER 333222000
ISSUE DATE 02/25/2004

	CLAIMS DATA			
	CURRENT NUMBER	CURRENT AMOUNT	YTD(**a**) NUMBER	YTD(**b**) AMOUNT
CLAIMS PAID	1	150.00	1	150.00
CLAIM ADJUSTMENTS	1	(25.00)	1	(25.00)
TOTAL CLAIMS PAYMENTS	1	125.00	1	125.00
CLAIMS DENIED	0		0	
CLAIMS IN PROCESS	0			

	EARNINGS DATA	
PAYMENTS:		
CLAIM PAYMENTS	150.00	150.00
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00
ACCOUNTS RECEIVABLE (OFFSETS):		
CLAIM SPECIFIC:		
CURRENT CYCLE	(25.00)	(25.00)
OUTSTANDING FROM PREVIOUS CYCLES	0.00	0.00
NON-CLAIM SPECIFIC OFFSETS	0.00	0.00
FICA WITHHELD	0.00	0.00
NET PAYMENT	125.00	125.00
REFUNDS:		
CLAIM SPECIFIC ADJUSTMENT REFUNDS	0.00	0.00
NON-CLAIM SPECIFIC REFUNDS	0.00	0.00
OTHER FINANCIAL:		
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00
VOIDS	0.00	0.00
NET EARNINGS	125.00	125.00

(a) and **(b)** Year to Date is running total of what the provider's 1099 will be at the end of the calendar year

Remittance Advice - Compound Drug Claims Paid Report Layout

```
REPORT:    CRA-0001-W                                   STATE OF OKLAHOMA                                   DATE:
MMDDYY
PROCESS:   FNIO3011                            MEDICAID MANAGEMENT INFORMATION SYSTEM                      PAGE:
9,999
LOCATION:  FINJW201                                 PROVIDER REMITTANCE ADVICE
                                                     COMPOUND DRUG CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              ISSUE DATE      MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


                        DISPENSE RENDERING        BILLED        ALLOWED      TPL         CO-PAY     SPENDDOWN      REIMB.         PAID
    --ICN--      RX NO.    DATE   PROVIDER         AMOUNT         AMOUNT     AMOUNT       AMOUNT      AMOUNT        AMOUNT        AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS XXXXXXX   MMDDYY  XXXXXXXXX   9,999,999.99   9,999,999.99  9,999,999.99  999,999.99  999,999.99  9,999,999.99
9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

    NDC        UNITS     ALLOWED     EOB CODES
  XXXXXXXXXXX 999999  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
    XXXXXXXXXXX 999999  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

         TOTAL COMPOUND DRUG CLAIMS PAID:                99,999,999.99             9,999,999.99            99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31

Field	Description	Data Type	Length
Allowed	The computed detail level allowed amount for dispensed drug under the Medical assistance program being billed.	Number	9
Allowed Amount	The computed dollar amount for the dispensed drug under the Medical Assistance Program being billed. This amount is determined by totaling prices of all ingredient used to formulate the compound.	Number	9
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9
City	City where payee resides.	Character	15
Client Number	Client's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	The dollar amount member should pay and is deducted from the allowed amount. The co-pay amount that is deducted depends on the type of drug dispensed.	Number	8
Dispense Date	The date drug was dispensed to member. This serves as the service date for drug claims.	Character	6
EOB Codes	The detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.	Number	4
Header EOBS	The EOB codes that apply to the header on the compound drug claim form. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date payment was issued.	Character	10
NDC	National Drug Codes correspond to the ingredients used. A maximum of 15 ingredients can be entered on one claim.	Character	11
Paid Amount	Dollar amount paid for drug. This is determined by computing allowable amount for drug and deducting TPL, and/or co-pay amounts.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated, this is the payment number corresponding to the check or EFT generated.	Number	9
Provider Name	Payee's name.	Character	50

Field	Description	Data Type	Length
RX NO.	Prescription number on the prescription used to dispense the drug.	Character	7
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9
Total Compound Drug Claims Paid - Allowed	Total amount allowed for payee claims.	Number	10
Total Compound Drug Claims Paid - Billed	Total amount billed for payee.	Number	10
Total Compound Drug Claims Paid - Co-Pay	Total amount of co-pay for payee’s claims.	Number	9
Total Compound Drug Claims Paid - Paid	Total amount paid for payee’s claims.	Number	10
Total Compound Drug Claims Paid - Reimbursement	Total amount reimbursed for payee’s claims.	Number	10
Total Compound Drug Claims Paid - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Claims Paid - TPL	Total amount of TPL for payee’s claims.	Number	10
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Compound Drug Claims Denied Report Layout

```
REPORT:    CRA-0002-W                                           STATE OF OKLAHOMA                                               DATE:
MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                     PAGE:
9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                            COMPOUND DRUG CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE      MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


                        DISPENSE RENDERING         BILLED        TPL          SPENDDOWN
    --ICN--     RX NO.    DATE   PROVIDER          AMOUNT       AMOUNT         AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS XXXXXXX  MMDDYY  XXXXXXXXX   9,999,999.99    9,999,999.99    999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

    NDC        UNITS   EOB CODES
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


     TOTAL COMPOUND DRUG CLAIMS DENIED:     99,999,999.99   99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Member's name.	Character	29
Dispense Date	Date drug was actually dispensed to member. This serves as service date for drug claims.	Character	8
EOB Codes	These are the Detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.	Number	4
Header EOBS	These are the EOB codes that apply to the header on the compound drug claim form. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date payment was issued.	Character	10
NDC	These are the National Drug Codes that pertain to the ingredients used in the compound. There is a maximum number of 15 ingredients that can be entered on one claim.	Character	11
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated, this is the payment number corresponding to the check or EFT generated.	Number	9
Provider Name	Payee's name.	Character	50
RX NO.	Indicates the prescription number on the prescription that was used to dispense the drug.	Character	7
Rendering Provider Number	The number used to identify the provider that performed the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2

Field	Description	Data Type	Length
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9
Total Compound Drug Claims Denied - Billed	Total amount billed by the payee.	Number	10
Total Compound Drug Claims Denied - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Claims Denied - TPL	Total amount of TPL for payee's claims.	Number	10
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Compound Drug Claims In Process Report Layout

```
REPORT:    CRA-0003-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                          COMPOUND DRUG CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


                        DISPENSE RENDERING         BILLED        TPL         SPENDDOWN
    --ICN--     RX NO.    DATE   PROVIDER          AMOUNT       AMOUNT        AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS XXXXXXX  MMDDYY  XXXXXXXXX   9,999,999.99    9,999,999.99    999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

    NDC        UNITS   EOB CODES
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XXXXXXXXXXX 999999   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

   TOTAL COMPOUND DRUG CLAIMS IN PROCESS:   99,999,999.99   99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9

Field	Description	Data Type	Length
City	The city in which the payee lives.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Dispense Date	Date drug was actually dispensed to member. This serves as service date for drug claims.	Character	8
EOB Codes	These are the detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.	Number	4
Header EOBS	These are the EOB codes that apply to the header on the compound drug claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA reason code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
NDC	These are the national drug codes that pertain to the ingredients used in the compound. There is a maximum of 15 ingredients that can be entered on one claim.	Character	11
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated, this is the check number corresponding to the check generated. If the provider is an EFT participant, this is the control number of the EFT transaction.	Number	9
Provider Name	Payee's name.	Character	50
RX NO.	Indicates the prescription number on the prescription used to dispense the drug.	Character	7
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State in which the payee resides.	Character	2
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9
Total Compound Drug Claims In Process - Billed	Total amount billed for payee.	Number	10

Field	Description	Data Type	Length
Total Compound Drug Claims In Process - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Claims In Process - TPL	Total amount of TPL for payee's claims.	Number	10
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Compound Drug Claim Adjustments Report Layout

```
REPORT:    CRA-0004-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                     PROVIDER REMITTANCE ADVICE
                                                      COMPOUND DRUG CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


                        DISPENSE RENDERING        BILLED        ALLOWED         TPL        CO-PAY   SPENDDOWN        REIMB.
PAID
    --ICN--      RX NO.    DATE   PROVIDER         AMOUNT         AMOUNT        AMOUNT      AMOUNT    AMOUNT          AMOUNT
AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBMOM XXXXXXX  MMDDYY  XXXXXXXXX (9,999,999.99)
(9,999,999.99)(9,999,999.99)(999,999.99)(999,999.99)(9,999,999.99)(9,999,999.99)
  RRYYJJJBBBSSS XXXXXXX  MMDDYY  XXXXXXXXX  9,999,999.99   9,999,999.99  9,999,999.99  999,999.99  999,999.99  9,999,999.99
9,999,999.99

    NDC        UNITS       ALLOWED   EOB CODES
  XXXXXXXXXXX 999999  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                                                    ADDITIONAL PAYMENT
9,999,999.99
                                                                    NET OVERPAYMENT
9,999,999.99
                                                  REFUND AMOUNT APPLIED                 9,999,999.99

   TOTAL COMPOUND DRUG ADJUSTMENT CLAIMS:                99,999,999.99             9,999,999.99            99,999,999.99
                                         99,999,999.99               99,999,999.99           9,999,999.99
9,999,999.99
```

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed	Computed detail-level dollar amount allowable for dispensed drug under the medical assistance program being billed.	Number	9
Allowed Amount	Computed dollar amount allowable for dispensed drug under the medical assistance program being billed. Pricing each ingredient used to formulate the compound and adding up the individual prices will produce this amount.	Number	9
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that the member should pay and is deducted from the allowed amount to arrive at the paid amount. The co-pay amount that is deducted depends on the type of drug dispensed.	Number	8
Dispense Date	Date drug was actually dispensed to member. This serves as service date for drug claims.	Character	8
EOB Codes	These are the EOB codes that apply to the header on the compound drug claim form. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBS	These are the EOB codes that apply to the header on the compound drug claim form. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4

Field	Description	Data Type	Length
ICN	Unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
NDC	These are the national drug codes that pertain to the compound ingredients. There is a maximum of 15 ingredients that can be entered on one claim.	Character	11
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Net Overpayment (AR)	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Paid Amount	Dollar amount paid for drug. Computing the allowable amount for the drug and deducting the TPL, and/or co-pay amounts determine this.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name.	Character	50
RX NO.	Indicates the prescription number on the prescription that was used to dispense the drug.	Character	7
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1

Field	Description	Data Type	Length
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9
Total Compound Drug Adjustments Claims Paid - Allowed	Total amount allowed for payee claims.	Number	10
Total Compound Drug Adjustments Claims Paid - Billed	Total amount billed for payee.	Number	10
Total Compound Drug Adjustments Claims Paid - Co-Pay	Total amount of co-pay for payee's claims.	Number	9
Total Compound Drug Adjustments Claims Paid - Paid	Total amount paid for payee's claims.	Number	10
Total Compound Drug Adjustments Claims Paid - Reimbursement	Total amount reimbursed for payee's claims.	Number	10
Total Compound Drug Adjustments Claims Paid - Spend down	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Adjustments Claims Paid - TPL	Total amount of TPL for payee's claims.	Number	10
Total No. Adj	Total count of number of adjustments on RA for the provider.	Number	6
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Dental Claims Paid Report Layout

```
REPORT:    CRA-0005-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                                DENTAL CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


                  RENDERING  SERVICE DATES          BILLED       ALLOWED         TPL     SPENDDOWN      CO-PAY         REIMB.
PAID
     --ICN--      PROVIDER   FROM     THRU          AMOUNT       AMOUNT         AMOUNT     AMOUNT       AMOUNT         AMOUNT
AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
  RRYYJJJBBBSSS   XXXXXXXXX  MMDDYY  MMDDYY   9,999,999.99  9,999,999.99  9,999,999.99  999,999.99  999,999.99   9,999,999.99
9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

 PL SERV  PROC CD  TOOTH  SURFACE  DATE SVC         BILLED       ALLOWED
                                     PERF           AMOUNT       AMOUNT    DETAIL EOBS
   XX     XXXXXX     99    XXXXX    MMDDYY    9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99    XXXXX    MMDDYY    9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99    XXXXX    MMDDYY    9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99    XXXXX    MMDDYY    9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

       TOTAL DENTAL CLAIMS PAID:             99,999,999.99               99,999,999.99            9,999,999.99
99,999,999.99
                                                           99,999,999.99              9,999,999.99              99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Allowed Amount	Computed dollar amount allowable for services rendered on each detail line under the medical assistance program being billed. May occur 12 times depending on the number of detail lines billed.	Number	9
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5

Field	Description	Data Type	Length
Paid Amount	Dollar amount paid for the services rendered. Computing allowable amount for the services and deducting the TPL amount determine this.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
Total Dental Claims Paid - Allowed	Total allowed amount for payee's claims.	Number	10
Total Dental Claims Paid - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Claims Paid - Co-Pay	Total amount of co-pay for payee's claims.	Number	9
Total Dental Claims Paid - Paid	Total amount paid for payee's claims.	Number	10
Total Dental Claims Paid - Reimbursement	Total amount reimbursed for payee's claims.	Number	10

Field	Description	Data Type	Length
Total Dental Claims Paid - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Claims Paid - TPL	Total amount of TPL for payee's claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Dental Claims Denied Report Layout

```
REPORT:    CRA-0006-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                               DENTAL CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


                 RENDERING    SERVICE DATES                BILLED        TPL         SPENDDOWN
     --ICN--     PROVIDER     FROM     THRU                AMOUNT       AMOUNT        AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXX    MMDDYY  MMDDYY          9,999,999.99    9,999,999.99    999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

 PL SERV  PROC CD  TOOTH  SURFACE  DATE SVC        BILLED
                                     PERF          AMOUNT      DETAIL EOBS
   XX     XXXXXX     99   99999     MMDDYY      9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                               9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99   99999     MMDDYY      9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                               9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99   99999     MMDDYY      9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                               9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99   99999     MMDDYY      9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                               9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99   99999     MMDDYY      9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                               9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

           TOTAL DENTAL CLAIMS DENIED:              99,999,999.99   99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9

Field	Description	Data Type	Length
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
Total Dental Claims Denied - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Claims Denied - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Claims Denied - TPL	Total amount of TPL for payee's claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Dental Claims In Process Report Layout

```
REPORT:    CRA-0007-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                             DENTAL CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXX, XX 99999-9999


                 RENDERING    SERVICE DATES                BILLED           TPL       SPENDDOWN
     --ICN--     PROVIDER     FROM     THRU                AMOUNT          AMOUNT      AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
  RRYYJJJBBBSSS  XXXXXXXXX    MMDDYY   MMDDYY          9,999,999.99    9,999,999.99    999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

 PL SERV  PROC CD  TOOTH  SURFACE  DATE SVC     BILLED
                                     PERF       AMOUNT      DETAIL EOBS
   XX     XXXXXX     99    XXXXX    MMDDYY   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99    XXXXX    MMDDYY   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99    XXXXX    MMDDYY   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99    XXXXX    MMDDYY   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX     99    XXXXX    MMDDYY   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                 TOTAL DENTAL CLAIMS IN PROCESS:    99,999,999.99   99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9

Field	Description	Data Type	Length
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
Total Dental Claims In Process - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Claims In Process - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Claims In Process - TPL	Total amount of TPL for payee's claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Dental Claim Adjustments Report Layout

REPORT: CRA-0008-W STATE OF OKLAHOMA DATE: MMDDYY
PROCESS: FNIO3011 MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE: 9,999
LOCATION: FINJW201 PROVIDER REMITTANCE ADVICE
DENTAL CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999

--ICN--	RENDERING PROVIDER	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	REIMB. PAID AMOUNT
CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX									
RRYYJJJBBBMOM	XXXXXXXXX	MMDDYY	MMDDYY	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(999,999.99)	(999,999.99)	(9,999,999.99) (9,999,999.99)
RRYYJJJBBBSSS	XXXXXXXXX	MMDDYY	MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	999,999.99	999,999.99	9,999,999.99 9,999,999.99

HEADER EOBS: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
XX	XXXXXX	99	99999	MMDDYY	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

ADDITIONAL PAYMENT 9,999,999.99

NET OVERPAYMENT 9,999,999.99

REFUND AMOUNT APPLIED 9,999,999.99

TOTAL NO. OF ADJ: 999,999

TOTAL DENTAL ADJUSTMENT CLAIMS:	99,999,999.99	99,999,999.99	9,999,999.99	9,999,999.99
	99,999,999.99	9,999,999.99		99,999,999.99

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	Computed dollar amount allowable for services rendered on each detail line under the medical assistance program being billed. May occur 12 times depending on the number of detail lines billed.	Number	9
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	Unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9

Field	Description	Data Type	Length
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5
Paid Amount	Dollar amount paid for the services rendered. This is determined by computing allowable amount for the services and deducting the TPL amount.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2

Field	Description	Data Type	Length
Total Dental Adjustments Claims - Allowed	Total allowed amount for payee's claims.	Number	10
Total Dental Adjustments Claims - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Adjustments Claims - Co-Pay	Total amount of co-pay for payee's claims.	Number	9
Total Dental Adjustments Claims - Paid	Total amount paid for payee's claims.	Number	10
Total Dental Adjustments Claims - Reimbursement	Total amount reimbursed for payee's claims.	Number	10
Total Dental Adjustments Claims - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Adjustments Claims - TPL	Total amount of TPL for payee's claims.	Number	10
Total No. Adj	Total count of number of adjustments on RA for the provider.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part B Claims Paid Report Layout

```
REPORT:    CRA-0017-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                    MEDICARE CROSSOVER PART B CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--     SERVICE DATES              SPENDDOWN        BLOOD    M E D I C A R E              M  E  D  I  C  A  I  D
     PAT NO.     FROM     THRU              COPAY AMT        DEDUCT   DEDUCT   CO-INS        BILLED   TPL AMT     REIMB AMT    PAID
AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
  RRYYJJJBBBSSS  MMDDYY MMDDYY              999,999.99    999,999.99        999,999.99            9,999,999.99
9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX            999,999.99             999,999.99           9,999,999.99            9,999,999.99

EOBS    00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        01  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        02  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        03  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        04  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        05  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

  TOTAL MEDICARE CROSSOVER PART B CLAIMS PAID:
                                        9,999,999.99  9,999,999.99      9,999,999.99           99,999,999.99
99,999,999.99
                                        9,999,999.99           9,999,999.99          99,999,999.99           99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31
Blood Deductible	Amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15

Field	Description	Data Type	Length
Client Number	Member’s Medicaid identification number.	Character	12
Client Name	Client’s name.	Character	29
Co-Pay AMT	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.	Number	8
EOB Sequence Code	This is the sequential line number of the EOB code line.	Number	2
EOBs	These are the Detail EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9

Field	Description	Data Type	Length
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Total Medicare Crossover Part B Claims Paid - Billed Amt	This amount reflects the total of all billed amounts for the Medicare Part B Crossover claims.	Number	10
Total Medicare Crossover Part B Claims Paid - Blood Deductible Amt	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Co - Insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Paid Amt	This amount reflects the total of all the Medicare Crossover Part B claims.	Number	10
Total Medicare Crossover Part B Claims Paid - Reimbursement	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part B claims.	Number	10
Total Medicare Crossover Part B Claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part B Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part B Claims Denied Report Layout

```
REPORT:    CRA-0018-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                   MEDICARE CROSSOVER PART B CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99990-9999


     --ICN--     SERVICE DATES                SPENDDOWN        BLOOD       M E D I C A R E       M  E  D  I  C  A  I  D
     PAT NO.     FROM     THRU                  AMOUNT         DEDUCT     DEDUCT      CO-INS      BILLED     TPL AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  MMDDYY MMDDYY               999,999.99    999,999.99            999,999.99              9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    999,999.99            9,999,999.99

EOBS    00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        01  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        02  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        03  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        04  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        05  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL MEDICARE CROSSOVER PART B CLAIMS DENIED:
                                          9,999,999.99  9,999,999.99          9,999,999.99             99,999,999.99
                                                                  9,999,999.99           99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31
Blood Deductible	This is the amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15

Field	Description	Data Type	Length
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBs	These are the Detail EOB codes that apply to the header on the claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-InsuranceAmount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2

Field	Description	Data Type	Length
Total Medicare Crossover Part B Claims Denied - Billed Amt	This amount reflects the total billed amount for the Medicare Part B Crossover claims.	Number	10
Total Medicare Crossover Part B Claims Denied - Blood Deductible Amt	This amount reflects the total amount of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Denied - Co - Insurance Amt	This amount reflects the total amount of all co-insurance amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Denied - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	10
Total Medicare Crossover Part B Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims.	Number	10
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part B Claims In Process Report Layout

```
REPORT:    CRA-0019-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                 MEDICARE CROSSOVER PART B CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                               PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                               ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--     SERVICE DATES                SPENDDOWN        BLOOD       M E D I C A R E       M  E  D  I  C  A  I  D
     PAT NO.     FROM     THRU                  AMOUNT         DEDUCT     DEDUCT      CO-INS      BILLED     TPL AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  MMDDYY MMDDYY               999,999.99    999,999.99             999,999.99               9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                      999,999.99             9,999,999.99

EOBS    00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        01  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        02  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        03  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        04  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        05  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL MEDICARE CROSSOVER PART B CLAIMS IN PROCESS:
                                          9,999,999.99  9,999,999.99          9,999,999.99             99,999,999.99
                                                                    9,999,999.99           99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Blood Deductible Amount	Amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12

Field	Description	Data Type	Length
Client Name	Client's name.	Character	29
EOB Codes	These are the Detail EOB codes that apply to the header on the claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part B	This amount reflects the total billed amount of all the Medicare Crossover Part B	Number	10

Field	Description	Data Type	Length
Claims in Process - Billed Amt	claims.		
Total Medicare Crossover Part B Claims in Process - Blood Deductible Amt	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims in Process - Co - Insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims in Process - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims in Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part B Claims in Process - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims.	Number	10
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part B Claim Adjustments Report Layout

```
REPORT:    CRA-0020-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                 MEDICARE CROSSOVER PART B CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--     SERVICE DATES               SPENDDOWN        BLOOD    M E D I C A R E              M  E  D  I  C  A  I  D
     PAT NO.     FROM     THRU               COPAY AMT        DEDUCT   DEDUCT   CO-INS        BILLED   TPL AMT     REIMB AMT    PAID
AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBMOM  MMDDYY MMDDYY             (999,999.99)  (999,999.99)      (999,999.99)          (9,999,999.99)
(9,999,999.99)
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           (999,999.99)           (999,999.99)         (9,999,999.99)          (9,999,999.99)
  RRYYJJJBBBSSS  MMDDYY MMDDYY              999,999.99    999,999.99        999,999.99            9,999,999.99
9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX            999,999.99             999,999.99           9,999,999.99            9,999,999.99


EOBS    00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        01  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                                                                ADDITIONAL PAYMENT
9,999,999.99
                                                                                NET OVERPAYMENT
9,999,999.99
                                                    REFUND AMOUNT APPLIED                    9,999,999.99

  TOTAL MEDICARE CROSSOVER PART B ADJUSTMENT CLAIMS:
                                          9,999,999.99  9,999,999.99      9,999,999.99           99,999,999.99
99,999,999.99
                                          9,999,999.99           9,999,999.99          99,999,999.99           99,999,999.99
```

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Blood Deductible Amount	This is the amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.	Number	8
EOB Codes	These are the Detail EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
ICN	This is the unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8

Field	Description	Data Type	Length
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee’s name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part B Adj Claims - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part B claims.	Number	10
Total Medicare Crossover Part B Adj Claims - Blood Deductible Amt	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Adj Claims - Co - Insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part B claims Adjustments.	Number	9
Total Medicare Crossover Part B Adj Claims - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part B claims Adjustments.	Number	9

Field	Description	Data Type	Length
Total Medicare Crossover Part B Adj Claims - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims Adjustments.	Number	9
Total Medicare Crossover Part B Adj Claims - Paid Amt	This amount reflects the total of all the Medicare Crossover Part B claims Adjustments.	Number	10
Total Medicare Crossover Part B Adj Claims - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part B claims Adjustments.	Number	10
Total Medicare Crossover Part B Adj Claims - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part B Adj Claims - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims Adjustments.	Number	10
Total No. Adj	This is the total number of claims adjusted for the current financial cycle.	Number	6
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Inpatient claims Paid Report Layout

```
REPORT:    CRA-0021-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:        9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                              INPATIENT CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


  --ICN--    ATTENDING PROV. SERVICE DATES   DAYS   ADMIT     BILLED AMT    ALLOWED AMT     SPENDDOWN        TPL AMT       PAID AMT
 PAT.ACCT NUM.               FROM     THRU          DATE                                    COPAY AMT      REIMB AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS XXXXXXXXXX    MMDDYY MMDDYY   999   MMDDYY   9,999,999.99   9,999,999.99    999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           999,999.99   9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                             LVL
REV CD HCPCS/RATE SRV DATE   CARE      UNITS     BILLED AMT  ALLOWED AMT   DETAIL EOBS
 999    XXXXXX     MMDDYY    XXX     999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX     999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX     999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX     999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX     999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                            TOTAL INPATIENT CLAIMS PAID:   99,999,999.99  99,999,999.99  9,999,999.99  99,999,999.99   99,999,999.99
                                                                                         9,999,999.99  99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Allowed Amount	The computed allowable dollar amount for claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Days	Total days member was in hospital.	Number	3
Detail EOBs	EOB codes.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBs	These are the Header EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates level of patient care.	Character	3
Paid Amount	The dollar amount payable for claim.	Number	9
Patient Acct Number	This is a unique number assigned by the provider usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9

Field	Description	Data Type	Length
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Inpatient claims Paid - Allowed Amt	This amount reflects the allowed amount total of all the inpatient claims.	Number	10
Total Inpatient claims Paid - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the inpatient claims paid.	Number	9
Total Inpatient claims Paid - Paid Amt	This amount reflects the total of all the inpatient claims paid.	Number	10
Total Inpatient claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the inpatient claims paid.	Number	10

Field	Description	Data Type	Length
Total Inpatient claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Inpatient claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the inpatient claims paid.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Inpatient claims Denied Report Layout

```
REPORT:    CRA-0022-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                              INPATIENT CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


   --ICN--    ATTENDING PROV. SERVICE DATES   DAYS   ADMIT         BILLED         TPL       SPENDDOWN
 PATIENT ACCT. NUM.          FROM     THRU          DATE         AMOUNT         AMOUNT      AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS   XXXXXXXXXX  MMDDYY MMDDYY   999   MMDDYY   9,999,999.99   9,999,999.99    999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999
                             LVL
REV CD HCPCS/RATE SRV DATE   CARE     UNITS     BILLED AMT    DETAIL EOBS
 999    XXXXXX     MMDDYY    XXX    999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX    999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX    999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX    999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    XXX    999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                            9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                          TOTAL INPATIENT CLAIMS DENIED:   99,999,999.99  99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
Detail EOBs	EOB codes.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBs	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates what level of care the patient was rendered.	Character	3
Patient Acct Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. These might occur 23 times depending on the number of detail lines billed.	Number	3

Field	Description	Data Type	Length
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Inpatient claims Denied - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Inpatient claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the denied inpatient claims.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Inpatient claims In Process Report Layout

```
REPORT:    CRA-0023-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                         INPATIENT CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


   --ICN--       ATTENDING  SERVICE DATES   DAYS   ADMIT         BILLED          TPL        SPENDDOWN
 PATIENT ACCT. NUM. PROV.  FROM     THRU          DATE          AMOUNT         AMOUNT       AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS   XXXXXXXXX  MMDDYY MMDDYY   999   MMDDYY      9,999,999.99   9,999,999.99    999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                          LVL
REV CD HCPCS/RATE SRV DATE  CARE        UNITS      BILLED AMT   DETAIL EOBS
 999    XXXXXX     MMDDYY   XXX       999999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  999    XXXXXX     MMDDYY    XXX       999999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY   XXX       999999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY   XXX       999999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                    TOTAL INPATIENT CLAIMS IN PROCESS:   99,999,999.99  99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number. Unique identifier of the client.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates what level of care the patient was rendered.	Character	3
Patient Acct Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3

Field	Description	Data Type	Length
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	This is the state in which the payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Inpatient claims In Process - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims In Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Inpatient claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the inpatient claims.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Inpatient Claim Adjustments Report Layout

```
REPORT:    CRA-0024-W                                   STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                              MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                    PROVIDER REMITTANCE ADVICE
                                                       INPATIENT CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                            PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                            ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


  --ICN--      ATTEND PROV.  SERVICE DATES   DAYS   ADMIT     BILLED AMT    ALLOWED AMT     SPENDDOWN        TPL AMT       PAID AMT
    --PATIENT ACCT NUM--     FROM     THRU          DATE                                    COPAY AMT      REIMB AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS   XXXXXXXXX  MMDDYY MMDDYY   999   MMDDYY  (9,999,999.99) (9,999,999.99)  (999,999.99) (9,999,999.99) (9,999,999.99)
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                (999,999.99) (9,999,999.99)
 RRYYJJJBBBSSS XXXXXXXXX    MMDDYY MMDDYY   999   MMDDYY   9,999,999.99   9,999,999.99    999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 999,999.99   9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY    XXX   999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                                                             ADDITIONAL PAYMENT
9,999,999.99
                                                                             NET OVERPAYMENT
9,999,999.99
                                                  REFUND AMOUNT APPLIED                  9,999,999.99

TOTAL NO. OF ADJ: 999,999
                    TOTAL INPATIENT ADJUSTMENT CLAIMS:    99,999,999.99  99,999,999.99  9,999,999.99  99,999,999.99   99,999,999.99
                                                                                       9,999,999.99  99,999,999.99
```

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Allowed Amount	The computed allowable dollar amount for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	The dollar amount billed by the provider for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	The dollar amount that the member should pay and is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	8
Days	Total days member was in hospital.	Number	3
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8

Field	Description	Data Type	Length
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is the unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates what level of care the patient was rendered.	Character	3
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Paid Amount	This is the dollar amount that is payable for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Patient Acct Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee’s name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid for the services by any source outside of the state Medical Assistance Program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total Inpatient claims Adjustments - Allowed Amt	This amount reflects the allowed amount total of all the inpatient claims.	Number	10
Total Inpatient claims Adjustments - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims Adjustments - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the inpatient claims.	Number	9
Total Inpatient claims Adjustments - Paid Amt	This amount reflects the total of all the inpatient claim adjustments.	Number	10
Total Inpatient claims Adjustments - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the inpatient claims Adjustments.	Number	10
Total Inpatient claims Adjustments - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Inpatient claims Adjustments - TPL Amt	This amount reflects the total of all TPL amounts for the inpatient claims adjustments.	Number	10
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6

Field	Description	Data Type	Length
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Outpatient Claims Paid Report Layout

```
REPORT:    CRA-0025-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                           OUTPATIENT CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999

    --ICN--      ATTEND PROV. SERVICE DATES        BILLED       ALLOWED         TPL         CO-PAY    SPENDDOWN        REIMB.
PAID
    --PATIENT NUMBER--        FROM     THRU        AMOUNT        AMOUNT        AMOUNT       AMOUNT      AMOUNT         AMOUNT
AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99   999,999.99   999,999.99  9,999,999.99
9,999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE  MODIFIERS      UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
999    XXXXXX     MMDDYY  XX XX XX XX  999999.99  9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99  9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99  9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

        TOTAL OUTPATIENT CLAIMS PAID:       99,999,999.99              99,999,999.99             9,999,999.99
9,999,999.99
                                                          99,999,999.99              9,999,999.99             99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Allowed Amount	The computed allowable dollar amount for claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBs	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Paid Amount	The dollar amount that is payable for the claim.	Number	9
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9

Field	Description	Data Type	Length
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid by sources other than the medical assistance program being billed for the member's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Outpatient Claims Paid - Allowed Amt	This amount reflects the allowed amount total of all outpatient claims.	Number	10
Total Outpatient Claims Paid - Billed Amt	This amount reflects the total billed amount of all the outpatient claims.	Number	10
Total Outpatient Claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the outpatient claims.	Number	9
Total Outpatient Claims Paid - Paid Amt	This amount reflects the total of all the Outpatient Claims paid.	Number	10
Total Outpatient Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the outpatient claims.	Number	10

Field	Description	Data Type	Length
Total Outpatient Claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Outpatient Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the outpatient claims paid.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Outpatient Claims Denied Report Layout

```
REPORT:    CRA-0026-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                             OUTPATIENT CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


    --ICN--      ATTEND PROV. SERVICE DATES        BILLED          TPL       SPENDDOWN
    --PATIENT NUMBER--        FROM     THRU        AMOUNT         AMOUNT      AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY  9,999,999.99   9,999,999.99    999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE  MODIFIERS      UNITS    BILLED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

          TOTAL OUTPATIENT CLAIMS DENIED:   99,999,999.99  99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Patient Number	This is the unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3

Field	Description	Data Type	Length
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
TPL Amount	This is the dollar amount paid by sources other than the medical assistance program being billed for the member's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Outpatient Claims Denied - Billed Amt	This amount reflects the total of all the outpatient claims billed for the provider.	Number	10
Total Outpatient Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Outpatient Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the provider's denied outpatient claim.	Number	10
Units	This shows the units of service rendered. These might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Outpatient Claims In Process Report Layout

```
REPORT:    CRA-0027-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                           OUTPATIENT CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


    --ICN--      ATTEND PROV. SERVICE DATES        BILLED          TPL       SPENDDOWN
    --PATIENT NUMBER--        FROM     THRU        AMOUNT         AMOUNT      AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY  9,999,999.99   9,999,999.99    999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE  MODIFIERS      UNITS    BILLED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

      TOTAL OUTPATIENT CLAIMS IN PROCESS:   99,999,999.99  99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBS	This is the line level EOB. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBs	EOB codes.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3

Field	Description	Data Type	Length
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid by sources other than the medical assistance program being billed for the member's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Outpatient Claims In Process - Billed Amt	This amount reflects the total of all the outpatient claims billed for the provider.	Number	10
Total Outpatient Claims In Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Outpatient Claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the outpatient claims in process.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Outpatient Claim Adjustments Report Layout

```
REPORT:    CRA-0028-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                     PROVIDER REMITTANCE ADVICE
                                                       OUTPATIENT CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                           PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                           ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999

    --ICN--      ATTEND PROV. SERVICE DATES        BILLED       ALLOWED         TPL         CO-PAY    SPENDDOWN        REIMB.
PAID
    --PATIENT NUMBER--        FROM     THRU        AMOUNT        AMOUNT        AMOUNT       AMOUNT      AMOUNT         AMOUNT
AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY (9,999,999.99)(9,999,999.99)(9,999,999.99) (999,999.99)
(999,999.99)(9,999,999.99)(9,999,999.99)
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99   999,999.99   999,999.99  9,999,999.99
9,999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 REV CD HCPCS/RATE SRV DATE  MODIFIERS      UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
999    XXXXXX     MMDDYY  XX XX XX XX  999999.99  9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                               9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                                                 ADDITIONAL PAYMENT
9,999,999.99
                                                                 NET OVERPAYMENT
9,999,999.99
                                                 REFUND AMOUNT APPLIED                  9,999,999.99
 TOTAL NO. OF ADJ: 999,999
     TOTAL OUTPATIENT ADJUSTMENT CLAIMS:    99,999,999.99              99,999,999.99              9,999,999.99
99,999,999.99
                                                        99,999,999.99              9,999,999.99              99,999,999.99
```

Field	Description	Data Type	Length
Additional Payment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	The computed allowable dollar amount for claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2

Field	Description	Data Type	Length
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Paid Amount	The dollar amount that is payable for the claim.	Number	9
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. These might occur 23 times depending on the number of detail lines billed.	Number	3
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	The state where payee resides.	Character	2

Field	Description	Data Type	Length
TPL Amount	Payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6
Total Outpatient Adjustment Claims - Allowed Amt	This amount reflects the allowed amount total of all the adjustment claims.	Number	10
Total Outpatient Adjustment Claims - Billed Amt	This amount reflects the total billed amount of all the adjustment claims.	Number	10
Total Outpatient Adjustment Claims - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the adjustment claims paid.	Number	9
Total Outpatient Adjustment Claims - Paid Amt	This amount reflects the total of all the adjustment claims paid.	Number	10
Total Outpatient Adjustment Claims - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the adjustment claims paid.	Number	10
Total Outpatient Adjustment Claims - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Outpatient Adjustment Claims - TPL Amt	This amount reflects the total of all TPL amounts for the adjustment claims paid.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part A Claims Paid Report Layout

```
REPORT:    CRA-0029-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                   MEDICARE CROSSOVER PART A CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--     SERVICE DATES      ADMIT  ATTENDING    SPENDDOWN        BLOOD      M E D I C A R E             M  E  D  I  C  A  I
D
     PAT NO.     FROM     THRU DAYS DATE   PROVIDER     COPAY AMT        DEDUCT     DEDUCT   CO-INS     BILLED     TPL AMT     REIMB
AMT    PAID AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  MMDDYY MMDDYY 999 MMDDYY  XXXXXXXXXX  999,999.99    999,999.99          999,999.99           9,999,999.99
9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       999,999.99               999,999.99        9,999,999.99
9,999,999.99

EOBS    00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        01  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        02  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        03  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        04  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        05  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

     TOTAL MEDICARE CROSSOVER PART A CLAIMS PAID:    9,999,999.99  9,999,999.99        9,999,999.99           99,999,999.99
9,999,999.99
                                                    9,999,999.99             9,999,999.99       99,999,999.99
99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the claim. There could be a maximum of 20 EOB codes. For detailed information on EOBs see HIPAA Reason Code.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable for the hospitalization stay.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8

Field	Description	Data Type	Length
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	12
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claims Paid - Billed Amt	This amount reflects the total billed amount of the Medicare Crossover Part A claims.	Number	10
Total Medicare Crossover Part A Claims Paid - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A claims paid.	Number	9
Total Medicare Crossover Part A Claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part A claims paid, for the provider.	Number	9
Total Medicare Crossover Part A Claims Paid - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claims paid.	Number	9
Total Medicare Crossover Part A Claims Paid - Deductible	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claims paid.	Number	9
Total Medicare Crossover Part A Claims Paid - Paid Amt	This amount reflects the total of all the Medicare Crossover Part A claims paid.	Number	10
Total Medicare Crossover Part A Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part A claims paid.	Number	10
Total Medicare Crossover Part A Claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claims paid.	Number	10

Field	Description	Data Type	Length
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part A Claims Denied Report Layout

```
REPORT:    CRA-0030-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                   MEDICARE CROSSOVER PART A CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--     SERVICE DATES      ADMIT  ATTENDING    SPENDDOWN        BLOOD          M E D I C A R E       M  E  D  I  C  A  I  D
     PAT NO.     FROM     THRU DAYS DATE   PROVIDER                      DEDUCT       DEDUCT       CO-INS        BILLED     TPL AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  MMDDYY MMDDYY 999 MMDDYY  XXXXXXXXXX  999,999.99    999,999.99               999,999.99              9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 999,999.99              9,999,999.99

EOBS    00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        01  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        02  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        03  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        04  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
        05  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

    TOTAL MEDICARE CROSSOVER PART A CLAIMS DENIED:   9,999,999.99  9,999,999.99             9,999,999.99            99,999,999.99
                                                                                  9,999,999.99             99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8
City	City where payee resides.	Character	15

Field	Description	Data Type	Length
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the claim. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insuranace Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	A one-byte alphabetic code used to indicate the location of the billing provider.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8

Field	Description	Data Type	Length
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claims Denied - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part A claims.	Number	10
Total Medicare Crossover Part A Claims Denied - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A Claims Denied.	Number	9
Total Medicare Crossover Part A Claims Denied - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claims denied.	Number	9
Total Medicare Crossover Part A Claims Denied - Deductible	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claims denied.	Number	10
Total Medicare Crossover Part A Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claims denied.	Number	10
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part A Claims in Process Report Layout

```
REPORT:    CRA-0031-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                 MEDICARE CROSSOVER PART A CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--     SERVICE DATES      ADMIT  ATTENDING    SPENDDOWN        BLOOD          M E D I C A R E       M  E  D  I  C  A  I
D
     PAT NO.     FROM     THRU DAYS DATE   PROVIDER                      DEDUCT       DEDUCT       CO-INS        BILLED     TPL AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  MMDDYY MMDDYY 999 MMDDYY  XXXXXXXXXX  999,999.99    999,999.99               999,999.99             9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 999,999.99              9,999,999.99

EOBS     00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
         01  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
         02  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
         03  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
         04  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
         05  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL MEDICARE CROSSOVER PART A CLAIMS IN PROCESS:   9,999,999.99  9,999,999.99             9,999,999.99             99,999,999.99
                                                                                  9,999,999.99             99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8

Field	Description	Data Type	Length
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the claim. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	A one-byte alphabetic code used to indicate the location of the billing provider.	Character	1

Field	Description	Data Type	Length
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claims in Process - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part A claims.	Number	10
Total Medicare Crossover Part A Claims in Process - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A claims in process.	Number	9
Total Medicare Crossover Part A Claims in Process - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claims in process.	Number	9
Total Medicare Crossover Part A Claims in Process - Deductible	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claims in process.	Number	9
Total Medicare Crossover Part A Claims in Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claims in Process - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claims in process.	Number	10
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Medicare Crossover Part A Claim Adjustments Report Layout

```
REPORT:    CRA-0032-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                  MEDICARE CROSSOVER PART A CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--     SERVICE DATES      ADMIT  ATTENDING    SPENDDOWN        BLOOD      M E D I C A R E             M  E  D  I  C  A  I
D
     PAT NO.     FROM     THRU DAYS DATE   PROVIDER     COPAY AMT        DEDUCT     DEDUCT   CO-INS     BILLED     TPL AMT     REIMB
AMT    PAID AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBMOM  MMDDYY MMDDYY 999 MMDDYY  XXXXXXXXXX (999,999.99)  (999,999.99)        (999,999.99)         (9,999,999.99)
(9,999,999.99)
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      (999,999.99)             (999,999.99)      (9,999,999.99)
(9,999,999.99)
  RRYYJJJBBBSSS  MMDDYY MMDDYY 999 MMDDYY  XXXXXXXXXX  999,999.99    999,999.99          999,999.99           9,999,999.99
9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       999,999.99               999,999.99        9,999,999.99
9,999,999.99


EOBS    00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                                                                ADDITIONAL PAYMENT
9,999,999.99
                                                                                NET OVERPAYMENT
9,999,999.99
                                                                REFUND AMOUNT APPLIED                  9,999,999.99

TOTAL NO. OF ADJ: 999,999
 TOTAL MEDICARE CROSSOVER PART A ADJUSTMENT CLAIMS:  9,999,999.99  9,999,999.99        9,999,999.99          99,999,999.99
99,999,999.99
                                                    9,999,999.99             9,999,999.99       99,999,999.99
```

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill. For example, some pharmacy programs require that the patient pay a specific amount toward each prescription filled. The fee will not be charged for the following members: individuals under 21, or members in nursing facilities and intermediate care facilities for the mentally retarded.	Number	8
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the adjusted claim. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable for the hospitalization stay.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9

Field	Description	Data Type	Length
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an account receivable (setup) transaction is established.	Number	9
PAT NO	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee’s name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claim Adjustments - Billed Amt	This amount reflects the total billed amount of the Medicare Crossover Part A claims.	Number	10

Field	Description	Data Type	Length
Total Medicare Crossover Part A Claim Adjustments - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A claim adjustments.	Number	9
Total Medicare Crossover Part A Claim Adjustments - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part A claim adjustments.	Number	9
Total Medicare Crossover Part A Claim Adjustments - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claim adjustments.	Number	9
Total Medicare Crossover Part A Claim Adjustments - Deductibles	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claim adjustments.	Number	9
Total Medicare Crossover Part A Claim Adjustments - Paid Amt	This amount reflects the total of all the Medicare Crossover Part A claim adjustments.	Number	10
Total Medicare Crossover Part A Claim Adjustments - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claim Adjustments - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claim adjustments.	Number	10
Total Medicare Crossover Part A Claims Adjustments - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part A claims.	Number	10
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Long Term Care Claims Paid Report Layout

```
REPORT:    CRA-0033-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                        LONG TERM CARE FACILITY CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXX, XX 99999-9999

    --ICN--      ATTEND PROV. SERVICE DATES DAYS             BILLED    ALLOWED        TPL     PATIENT      REIMB.         PAID
    --PATIENT NUMBER--        FROM     THRU                  AMOUNT    AMOUNT        AMOUNT  LIABILITY     AMOUNT       AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY 999        9,999,999.99            9,999,999.99          9,999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                9,999,999.99              999,999.99            9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

         TOTAL LONG TERM CARE FACILITY CLAIMS PAID:   99,999,999.99           99,999,999.99         99,999,999.99
                                                                 99,999,999.99           9,999,999.99            99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31
Allowed Amount	This is the computed allowable amount for the services billed.	Number	9
Attend Prov	Number used to identify provider performing the service.	Number	10

Field	Description	Data Type	Length
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This indicates level of care rendered for patient.	Character	3
Paid Amount	This is the dollar amount that is payable for the member's stay.	Number	9
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50

Field	Description	Data Type	Length
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Long Term Care Claims Paid - Allowed Amt	This amount reflects the allowed amount total of all the Long Term Care claims paid.	Number	10
Total Long Term Care Claims Paid - Billed Amt	This amount reflects the total billed amount of the Long Term Care claims.	Number	10
Total Long Term Care Claims Paid - Paid Amt	This amount reflects the total of all the Long Term Care claims paid.	Number	10
Total Long Term Care Claims Paid - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims paid.	Number	9
Total Long Term Care Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Long Term Care claims paid.	Number	10
Total Long Term Care Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims paid.	Number	10
Units	This is the number of units of service.	Number	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Long Term Care Claims Denied Report Layout

```
REPORT:    CRA-0034-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                      LONG TERM CARE FACILITY CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXX, XX 99999-9999


    --ICN--      ATTEND PROV. SERVICE DATES DAYS             BILLED          TPL        PATIENT
    --PATIENT NUMBER--         FROM     THRU                 AMOUNT         AMOUNT     LIABILITY

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY 999        9,999,999.99   9,999,999.99    999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS    BILLED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

      TOTAL LONG TERM CARE FACILITY CLAIMS DENIED:    99,999,999.99  99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31
Attend Prov	Number used to identify provider performing the service.	Number	10

Field	Description	Data Type	Length
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This indicates level of care rendered for patient.	Character	3
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3

Field	Description	Data Type	Length
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Long Term Care Claims Denied - Billed Amt	This amount reflects the total billed amount of all the Long Term Care claims.	Number	10
Total Long Term Care Claims Denied - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims denied.	Number	9
Total Long Term Care Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims denied.	Number	10
Units	This is the number of units of service.	Number	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Long Term Care Claims In Process Report Layout

```
REPORT:    CRA-0035-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                    LONG TERM CARE FACILITY CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


    --ICN--      ATTEND PROV. SERVICE DATES DAYS             BILLED          TPL        PATIENT
    --PATIENT NUMBER--        FROM     THRU                  AMOUNT         AMOUNT     LIABILITY

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY 999        9,999,999.99   9,999,999.99    999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS    BILLED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

  TOTAL LONG TERM CARE FACILITY CLAIMS IN PROCESS:    99,999,999.99  99,999,999.99  9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31
Attending Prov	Number used to identify provider performing the service.	Number	10

Field	Description	Data Type	Length
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	The first name of the client.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This indicates level of care rendered for patient.	Character	3
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	This unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3

Field	Description	Data Type	Length
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Long Term Care Claims In Process - Billed Amt	This amount reflects the total billed amount of the Long Term Care Claims.	Number	10
Total Long Term Care Claims In Process - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims in process.	Number	9
Total Long Term Care Claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims in process.	Number	10
Units	This is the number of units of service.	Number	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Long Term Care Claim Adjustments Report Layout

```
REPORT:    CRA-0036-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                  LONG TERM CARE FACILITY CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


    --ICN--      ATTEND PROV. SERVICE DATES DAYS             BILLED    ALLOWED        TPL     PATIENT      REIMB.        PAID
    --PATIENT NUMBER--        FROM     THRU                 AMOUNT    AMOUNT        AMOUNT  LIABILITY     AMOUNT       AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY 999       (9,999,999.99)          (9,999,999.99)        (9,999,999.99)
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  (9,999,999.99)           (999,999.99)          (9,999,999.99)
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY 999        9,999,999.99            9,999,999.99          9,999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   9,999,999.99              999,999.99            9,999,999.99

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                         9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY    999   999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                         9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                                                              ADDITIONAL PAYMENT
9,999,999.99
                                                                              NET OVERPAYMENT
9,999,999.99
                                                    REFUND AMOUNT APPLIED                    9,999,999.99

TOTAL NO. OF ADJ: 999,999
   TOTAL LONG TERM CARE FACILITY ADJUSTMENT CLAIMS:   99,999,999.99           99,999,999.99         99,999,999.99
                                                                  99,999,999.99            9,999,999.99            9,999,999.99
```

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	This is the computed allowable amount for the services billed. The data displayed pertain to the adjusted claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This Might occur 23 times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	Unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	Indicates level of care rendered for patient.	Character	3

Field	Description	Data Type	Length
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Paid Amount	This is the dollar amount that is payable for the member's stay.	Number	9
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee’s name	Character	50
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes. The data displayed pertain to the adjusted claim.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1

Field	Description	Data Type	Length
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid for the services by any source outside of the state Medical Assistance program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total Long Term Care Claims ADJ - Allowed Amt	This amount reflects the allowed amount total of all the Long Term Care claims adjustments.	Number	10
Total Long Term Care Claims ADJ - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part A claims.	Number	10
Total Long Term Care Claims ADJ - Paid Amt	This amount reflects the total of all the Long Term Care claims adjustments.	Number	10
Total Long Term Care Claims ADJ - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims adjustments.	Number	9
Total Long Term Care Claims ADJ - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Long Term Care claims adjustments.	Number	10
Total Long Term Care Claims ADJ - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims adjustments.	Number	10
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6
Units	This is the number of units of service.	Number	8
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - Home Health Claims Paid Report Layout

```
REPORT:    CRA-0041-W                                        STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                      PROVIDER REMITTANCE ADVICE
                                                           HOME HEALTH CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                    PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


    --ICN--      ATTEND PROV. SERVICE DATES        BILLED       ALLOWED         TPL         CO-PAY    SPENDDOWN        REIMB.
PAID
    --PATIENT NUMBER--        FROM     THRU        AMOUNT       AMOUNT         AMOUNT       AMOUNT     AMOUNT          AMOUNT
AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXX   MMDDYY MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99   999,999.99   999,999.99  9,999,999.99
9,999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD HCPCS/RATE SRV DATE  MODIFIERS      UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX     MMDDYY  XX XX XX XX  999999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

      TOTAL HOME HEALTH CLAIMS PAID:       99,999,999.99              99,999,999.99              9,999,999.99
99,999,999.99
                                                          99,999,999.99              9,999,999.99              99,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31

Field	Description	Data Type	Length
Allowed Amount	This is the computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed. Adding all the allowable amounts for all the services described on the detail lines arrives at this amount.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	This is the dollar amount billed by the provider for the services rendered.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Detail EOBS	These are the EOB codes that apply to the claim detail lines. These codes are used to explain why the claim was denied. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Paid Amount	This is the dollar amount that is payable for the services rendered. This represents the allowable amount plus the overhead amount, minus the TPL and deductible amounts.	Number	9

Field	Description	Data Type	Length
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Payments made by sources outside of the state Medical Assistance Programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Total Home Health Claims Paid - Allowed Amt	This amount reflects the allowed amount total of all the Home Health Claims paid.	Number	10
Total Home Health Claims Paid - Billed Amt	This amount reflects the total billed amount of all the Home Health claims.	Number	10
Total Home Health Claims Paid - Co-Pay	This amount reflects the total of co-pay amounts for all the Home Health claims paid.	Number	9
Total Home Health Claims Paid - Paid Amt	This amount reflects the total of all the Home Health claims paid.	Number	10

Field	Description	Data Type	Length
Total Home Health Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Home Health claims paid.	Number	10
Total Home Health Claims Paid Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Home Health Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Home Health claims paid.	Number	10
Units	This shows the units of service rendered on the claim. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - CMS-1500 Claims Denied Report Layout

```
REPORT:    CRA-0114-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                              CMS 1500 CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--                  SERVICE DATES                   BILLED            TPL       SPENDDOWN
      --PATIENT NUMBER--      FROM     THRU                   AMOUNT          AMOUNT        AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
  RRYYJJJBBBSSS               MMDDYY MMDDYY             9,999,999.99    9,999,999.99     999,999.99
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                       SERVICE DATES RENDERING         BILLED
PL SERV  PROC CD  MODIFIERS   UNITS     FROM   THRU  PROVIDER          AMOUNT   DETAIL EOBS
   XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                     TOTAL CMS 1500 CLAIMS DENIED:    99,999,999.99   99,999,999.99   9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31

Field	Description	Data Type	Length
Billed Amount	This is the total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBS	These are the EOB codes that apply to each detail line on the claim form. See HIPAA Reason Code for detailed information on EOBs.	Character	4
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Character	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur six times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur six times depending on the number of detail lines billed.	Character	5
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Payments made by sources outside of the state Medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Total CMS-1500 Claims Denied - Billed Amt	This amount reflects the total billed amount of all the CMS-1500 claims.	Number	10
Total CMS-1500 Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total CMS-1500 Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the CMS-1500 claims denied.	Number	10
Units	This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed.	Number	6
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - CMS-1500 Claims In Process Report Layout

```
REPORT:    CRA-0115-W                                           STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                   MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                         PROVIDER REMITTANCE ADVICE
                                                            CMS 1500 CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--                  SERVICE DATES                   BILLED          TPL         SPENDDOWN
      --PATIENT NUMBER--      FROM     THRU                   AMOUNT          AMOUNT        AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
  RRYYJJJBBBSSS               MMDDYY MMDDYY             9,999,999.99    9,999,999.99     999,999.99
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                       SERVICE DATES RENDERING         BILLED
PL SERV  PROC CD  MODIFIERS   UNITS     FROM   THRU  PROVIDER          AMOUNT   DETAIL EOBS
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                 TOTAL CMS 1500 CLAIMS IN PROCESS:    99,999,999.99   99,999,999.99   9,999,999.99
```

Field	Description	Data Type	Length
Address	Payee’s address.	Character	31

Field	Description	Data Type	Length
Billed Amount	This is the total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBS	These are the EOB codes that apply to each detail line on the claim form. See HIPAA Reason Code for detailed information on EOBs.	Character	4
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Character	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur six times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur six times depending on the number of detail lines billed.	Character	5
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Payments made by sources outside of the state Medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Total CMS-1500 Claims In Process - Billed Amt	This amount reflects the total billed amount of all the CMS-1500 claims.	Number	10
Total CMS-1500 Claims In Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total CMS-1500 Claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the CMS-1500 claims in process.	Number	10
Units	This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed.	Number	6
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice - CMS-1500 Claim Adjustments Report Layout

```
REPORT:    CRA-0116-W                                            STATE OF OKLAHOMA
DATE:  MMDDYY
PROCESS:   FNIO3011                                    MEDICAID MANAGEMENT INFORMATION SYSTEM
PAGE:       9,999
LOCATION:  FINJW201                                          PROVIDER REMITTANCE ADVICE
                                                             CMS 1500 CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PAYEE NUMBER
999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PAYMENT NUMBER
999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    ISSUE DATE
MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


     --ICN--                 SERVICE DATES             BILLED       ALLOWED         TPL     SPENDDOWN      CO-PAY        REIMB.
PAID
      --PATIENT NUMBER--     FROM     THRU             AMOUNT        AMOUNT        AMOUNT     AMOUNT       AMOUNT        AMOUNT
AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
  RRYYJJJBBBSSS              MMDDYY MMDDYY      (9,999,999.99)             (9,999,999.99)           (999,999.99)
(9,999,999.99)
      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          (9,999,999.99)             (999,999.99)            (9,999,999.99)
  RRYYJJJBBBSSS              MMDDYY MMDDYY       9,999,999.99               9,999,999.99             999,999.99
9,999,999.99
      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                           9,999,999.99               999,999.99              9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                       SERVICE DATES RENDERING        BILLED       ALLOWED
PL SERV  PROC CD  MODIFIERS   UNITS     FROM   THRU  PROVIDER         AMOUNT       AMOUNT    DETAIL EOBS
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                             9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                             9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                             9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
```

```
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                              9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                              9999 9999 9999 9999 9999 9999 9999 9999
9999 9999


                                                                    ADDITIONAL PAYMENT
9,999,999.99
                                                                    NET OVERPAYMENT
9,999,999.99
                                                REFUND AMOUNT APPLIED                 9,999,999.99

         TOTAL NO. OF ADJ: 999,999
         TOTAL CMS 1500 ADJUSTMENT CLAIMS:     99,999,999.99             99,999,999.99           9,999,999.99
99,999,999.99
                                                                 99,999,999.99            9,999,999.99            99,999,999.99
```

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	This is the computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed. Adding all the allowable amounts for all the services described on the detail lines arrives at this amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Billed Amount	This is the total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detail lines arrives this at. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29

Field	Description	Data Type	Length
Co-Pay Amount	The dollar amount that the member should pay and is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	8
Detail EOBS	These are the EOB codes that apply to each detail line on the claim form. See HIPAA Reason Code for detailed information on EOBs.	Character	4
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Character	4
ICN	This is a unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur six times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Character	2
PROC CD	This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur six times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Character	5
Paid Amount	This is the dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the TPL amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9

Field	Description	Data Type	Length
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid for the services by any source outside of the state Medical Assistance program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total CMS-1500 Claims Adj Paid - Allowed Amt	This amount reflects the allowed amount total of all the CMS-1500 claims adjustments paid.	Number	10

Field	Description	Data Type	Length
Total CMS-1500 Claims Adj Paid - Billed Amt	This amount reflects the total billed amount of all the CMS- 1500 claims.	Number	10
Total CMS-1500 Claims Adj Paid - Co-Pay Amt	This amount reflects the total of Co-pay amounts for all the CMS-1500 claims adjustments paid.	Number	9
Total CMS-1500 Claims Adj Paid - Paid Amt	This amount reflects the total of all the CMS-1500 claims adjustments paid.	Number	10
Total CMS-1500 Claims Adj Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the CMS-1500 Claims Adjustments Paid.	Number	10
Total CMS-1500 Claims Adj Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total CMS-1500 Claims Adj Paid - TPL Amt	This amount reflects the total of all TPL amounts for the CMS-1500 claims adjustments paid.	Number	10
Total No. Adj	This is the total number of claims adjusted for the current financial cycle.	Number	6
Units	This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Number	6
Zip Code	Payee’s zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice Summary Report Layout

```
REPORT:   CRA-0148-W                    STATE OF OKLAHOMA                    DATE:  MMDDYY
PROCESS:  FNIO3011                MEDICAID MANAGEMENT INFORMATION SYSTEM     PAGE:
9,999
LOCATION: FINJW201                      PROVIDER REMITTANCE ADVICE
                                              SUMMARY


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                PAYEE NUMBER      999999999
X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYMENT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   ISSUE DATE        MMDDYY
XXXXXXXXXXXXXXXX, XX 99999-9999


                                          -------------------------CLAIMS DATA---------------------------

                                           CURRENT         CURRENT          YEAR-TO-DATE     YEAR-TO-DATE
                                            NUMBER         AMOUNT             NUMBER           AMOUNT
        CLAIMS PAID                        999,999      9,999,999.99         9,999,999      99,999,999.99
        CLAIM ADJUSTMENTS                  999,999      9,999,999.99         9,999,999      99,999,999.99
           TOTAL CLAIMS PAYMENTS           999,999      9,999,999.99         9,999,999      99,999,999.99
        CLAIMS DENIED                      999,999                           9,999,999
        CLAIMS IN PROCESS                  999,999                           9,999,999

                                                    ----------------------EARNINGS DATA----------------------
        PAYMENTS:
           REIMBURSEMENT AMOUNT                        9,999,999.99                      99,999,999.99
           STATE SHARE AMOUNT                         (9,999,999.99)                    (99,999,999.99)
                                                      -------------                     ---------------
           CLAIMS PAYMENTS                             9,999,999.99                      99,999,999.99

           CAPITATION PAYMENT†                         9,999,999.99                      99,999,999.99
           SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)         9,999,999.99                      99,999,999.99
           ACCOUNTS RECEIVABLE (OFFSETS):
              CLAIM SPECIFIC:
                 CURRENT CYCLE                        (9,999,999.99)                    (99,999,999.99)
                 OUTSTANDING FROM PREVIOUS CYCLES     (9,999,999.99)                    (99,999,999.99)
              NON-CLAIM SPECIFIC OFFSETS              (9,999,999.99)                    (99,999,999.99)

           NET PAYMENT**                               9,999,999.99                      99,999,999.99

        REFUNDS:
           CLAIM SPECIFIC ADJUSTMENT REFUNDS           (9,999,999.99)                    (99,999,999.99)
           NON CLAIM SPECIFIC REFUNDS                  (9,999,999.99)                    (99,999,999.99)
```

```
          OTHER FINANCIAL:
             MANUAL PAYOUTS (NON-CLAIM SPECIFIC)              9,999,999.99                    99,999,999.99
             VOIDS                                           (9,999,999.99)                  (99,999,999.99)

          NET EARNINGS                                        9,999,999.99                    99,999,999.99

          FICA WITHHELD                                       9,999,999.99                    99,999,999.99


**  NET PAYMENT AMOUNT HAS BEEN REDUCED.  LIEN PAYMENTS HAVE BEEN MADE TO THE FOLLOWING LIEN HOLDERS.

† CAPITATION PAYMENT FOR THE MONTH OF MM/YY.  PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR ADDITIONAL DETAIL.
```

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Check/EFT Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
City	City where payee resides.	Character	15
Current Amount Capitation Payment	The total dollar amount of the capitation payment for the current month. This dollar amount will only be reported on the first financial cycle of every month. In addition, this number will be reported on the RA only for those providers receiving administrative payments during the current year.	Number	9
Current Amount Claim Adjustments	The total net dollar amount of all positive adjustments finalized during the current financial cycle. Negative adjustments that result in an A/R are reported below in the offsets section. Refund adjustments are reported in the Refunds section of the RA.	Number	9
Current Amount Claim Specific A/R (Offsets Current Cycle)	The total dollar amount of all claim specific A/R established during the current financial cycle.	Number	9
Current Amount Claim Specific Adjustment Refunds	The sum dollar amount of all claim specific refunds received and applied during the current weekly financial cycle.	Number	9
Current Amount Claims Paid	The total dollar amount of the claims paid during the current weekly financial cycle.	Number	9
Current Amount Claims Payments	The total dollar amount of all claims paid and positive adjustments finalized from the current weekly financial cycle. This number is propagated from the Total Claims Payment field of the Claims Data section.	Number	9

Field	Description	Data Type	Length
Current Amount FICA Withheld	This is the amount of FICA withheld for certain provider types for the current period.	Number	9
Current Amount Lien Holder Payment	The total dollar amount that is being paid to the lien holder during the current weekly financial cycle. If there is more than one lien holder, each lien will be printed separately.	Number	9
Current Amount Manual Payouts (Non Claim Specific)	Manual payouts entered into the system during the current financial cycle. This only includes those checks that were issued outside the system through a manual checkwrite versus a system payout that is issued through the system.	Number	9
Current Amount Net Earnings	Calculates the net earnings for the current weekly financial cycle. Calculation is as follows: Payments and manual payouts less offsets, refunds and voids.	Number	9
Current Amount Net Payment	The sum of all claims payments less any offsets for the current financial cycle. This amount will equal the provider's weekly payment and the provider's checkwrite. NOTE: If a lien has been assessed against a provider's payments, this number will still represent the total net payment for the provider, but the checkwrite will be the payment less any lien payment amounts. A double asterisk (**) next to the net payment amount denotes that the actual check amount will be reduced by a lien assessed against a provider's payments.	Number	9
Current Amount Non Claim Specific Offsets	The total dollar amount of all non-claim specific accounts receivables established during the current financial cycle.	Number	9
Current Amount Non Claim Specific Refunds	The sum dollar amount of all non-claim specific refunds received and applied during the current weekly financial cycle.	Number	9
Current Amount Outstanding A/R from Prev Cycles	The dollar amount of all claim specific A/R established in previous cycles which have not been satisfied.	Number	9
Current Amount State Share Amount	This is the amount of state share (a negative amount) for the current period.	Number	9
Current Amount System Payouts (Non Claim Specific)	The total dollar amount of all non-claim specific payouts made to the provider for the current financial cycle.	Number	9
Current Amount Total Claims Payments	The total dollar amount of all claims paid and the net dollar amount of all positive adjustments finalized during the current weekly cycle.	Number	9

Field	Description	Data Type	Length
Current Amount Voids	The total dollar amount of all EDS issued checks that were voided during the current weekly financial cycle.	Number	9
Current Number Claim Adjustments	Net dollar amount of all positive adjustments finalized during the current financial cycle. Negative adjustments that result in an A/R are reported below in the offsets section. Refund adjustments are reported in the Refunds section of the RA.	Number	6
Current Number Claims Denied	The total number of claims denied during the current financial cycle.	Number	6
Current Number Claims Paid	The total number of claims paid during the current weekly financial cycle.	Number	6
Current Number Claims in Process	The total number of claims in process during the current weekly financial cycle.	Number	6
Current Number Total Claims Payments	The total number of claims paid and adjustments finalized during the current weekly financial cycle.	Number	6
Issue Date	Date check was issued.	Character	10
Lien Holder Name	Prints the name of the lien holder if a lien has been assessed against a provider's payments.	Number	39
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated to the billing provider for this week's cycle, this is the check number corresponding to the check that was generated. If the provider is an EFT participant, this is the control number of the EFT transaction.	Number	9
Provider Name	Payee’s name	Character	50
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
Y-T-D Amount Capitation Payment	The total dollar amount of the capitation payment year to date. This number will be reported on the RA only for those providers who have received admin payments during the current year.	Number	10
Y-T-D Amount Claim Specific A/R (Offsets Current Cycle)	The total dollar amount of all current cycle claim specific A/R established year to date. This will be equal to the current cycle amount. Accumulated year to date totals for claims specific offsets will be reported in the previous cycle A/R year to date field.	Number	10
Y-T-D Amount Claim Specific Adjustment Refunds	The sum dollar amount of all claims specific refunds received and applied year to date.	Number	10

Field	Description	Data Type	Length
Y-T-D Amount Claims Adjustments	Net dollar amount of all positive adjustments finalized year to date negative and refund adjustments are reported elsewhere on the RA.	Number	10
Y-T-D Amount Claims Paid	The total dollar amount of claims paid year to date.	Number	10
Y-T-D Amount Claims Payments	The total dollar amount of all claims paid and the net dollar amount of all positive adjustments finalized year to date.	Number	10
Y-T-D Amount FICA Withheld	This is the amount of FICA withheld for the year-to-date for certain provider types.	Number	10
Y-T-D Amount Lien Holder Payment	The total dollar amount that has been paid to the lien holder year to date.	Number	10
Y-T-D Amount Manual Payouts (Non Claim Specific)	Manual payouts issued year to date.	Number	10
Y-T-D Amount Net Earnings	Calculates the net earnings year to date (calculation is the same as above).	Number	10
Y-T-D Amount Net Payment	The sum of all claims payments less any offsets year to date.	Number	10
Y-T-D Amount Non Claim Specific Refunds	The sum dollar amount of all non-claim specific refunds received and applied year to date.	Number	10
Y-T-D Amount Non-Claim Specific Offsets	The total dollar amount of all non-claim specific A/Rs established year to date.	Number	10
Y-T-D Amount Outstanding A/R from Prev Cycles	The total dollar amount of all claim specific A/Rs established year to date.	Number	10
Y-T-D Amount State Share Amount	This is the amount of state share (a negative amount) for year-to-date.	Number	10
Y-T-D Amount System Payouts (Non-Claim Specific)	The total dollar amount of all non-claim specific payouts made to the provider year to date.	Number	10
Y-T-D Amount Total Claims Payments	The total dollar amount of all claims paid and positive adjustments finalized year to date. This number is propagated from the Total Claims Payment field of the Claims Data section.	Number	10
Y-T-D Amount Voids	The total dollar amount of all voids for year.	Number	10
Y-T-D Number Claims Adjustments	The total number of adjustments finalized year to date.	Number	7

Field	Description	Data Type	Length
Y-T-D Number Claims Denied	The total number of claims denied year to date.	Number	7
Y-T-D Number Claims In Process	The total number of claims in process year to date.	Number	7
Y-T-D Number Claims Paid	The total number of claims paid year to date.	Number	7
Y-T-D Number Total Claims Payments	The total number of claims paid and adjustments finalized year to date.	Number	7
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

SECTION C: ELECTRONIC REMITTANCE ADVICE

An electronic RA is available by using the X12 835 transaction as mandated under HIPAA. The 835 transaction is available to all OHCA providers and contracted trading partners that have requested electronic RAs. The 835 is a financial transaction that functions as an electronic means of posting accounts receivable. It is not intended to be equivalent to the paper RA and does not include detailed denial explanations.

The 835 Transaction is available from the Web or Remote Access Server (RAS) in a downloadable file. If other media is required (for example: tape or diskette), it is the provider's responsibility to contact EDS to make other arrangements.

The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. Oklahoma Medicaid will be providing a supplemental transaction that will provide claim status information on pended claims. This transaction is the 277 Health Care Payer Unsolicited Claim Status.

SECTION D: 1099 & W-2S

Annual earnings, based on the unique Tax Identification Number (TIN), are reported on IRS Form 1099 and submitted to each provider and the Internal Revenue Service. All money earned by TIN is reported on the Form 1099, based on an untaxed basis. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.

Additionally, an IRS Form W-2 is generated to report earnings and FICA contributions to the OCHA's Individual Personal Care Services providers. All money earned and FICA withholdings for each of these providers is reported on the Form W-2. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.

SECTION E: STOP PAYMENTS, VOIDS, RE-ISSUANCE

STOP PAYMENTS

Stop Payments occur when a provider indicates a check was not received. If the provider has not received a check, a stop payment request is necessary so that a replacement check can be issued. If a check is incorrectly issued, the stop payment request is necessary to prevent the funds from being disbursed in error.

A provider may call to request that a stop payment be placed on a check that was not received. In order for a payment to be reissued, the original check must first be stopped in the OKMMIS, and the OHCA manually reissues the provider a system-generated replacement check. The check can be resubmitted anytime and will be printed in the next manual check print run.

CHECK VOIDS

There are two types of voids that can occur within the OKMMIS: regular check voids and check void/reissue

Regular Check Voids

The first type, a regular void, occurs for any of the following reasons:

- The individual receiving treatment, listed on the RA, is not a patient of the provider who received the check.
- A payment was received by the wrong provider, and the check is returned to the OHCA with 'void' or 'not ours' written on the face of the check.
- A check was paid to a provider who does not belong to the group or has left the group.
- The payment was inappropriately made payable to the wrong location or provider identification number.
- The check is cancelled by statute and the OHCA directs that a void can be completed.

In the above situations, the checks would be voided within the OKMMIS and all claims associated with the dollars identified to this check will become denied claims. In order to receive payment for any of the now voided claims, it will be necessary for the provider to resubmit the claims.

Check Void/Reissue

The second type of voided check is a Void/Reissue. Void/Reissue items are a result of a check being mutilated or destroyed and a subsequent reissued check being manually prepared.

SECTION F: ELECTRONIC CARE COORDINATION PAYMENTS

The 820 Transaction Set is the HIPAA compliant financial transaction used to transmit care coordination payments. The 820 Transaction Set is generated by the Oklahoma OKMMIS and is distributed to primary care providers/case managers (PCP/CMs) who request electronic capitation reports and participate in the SoonerCare Choice program.

The 820 Care Coordination Payment is combined with the last financial cycle of the month. This transaction is used for the Premium Payment Remittance Information (PPRI).

Total payment amount noted in the BPR02 segment of the 820 Transaction may or may not equal the actual payment amount. This is due to the integration of the premium payment with fee-for-service claims payment in the same weekly financial cycle.

The 820 Transaction is only available by download via the Web or RAS. The PCP/CMs must contact EDS to make other arrangements if other media is required.

Appendices

- Banner Page
- CMS-1500 Claims Paid Page
- CMS-1500 Claims Denied Page
- CMS-1500 Claims In Process Page
- CMS-1500 Claim Adjustments Page
- Provider Remittance Advice Summary
- Explanation of Benefit Codes

Provider Remittance Advice Banner Messages Example

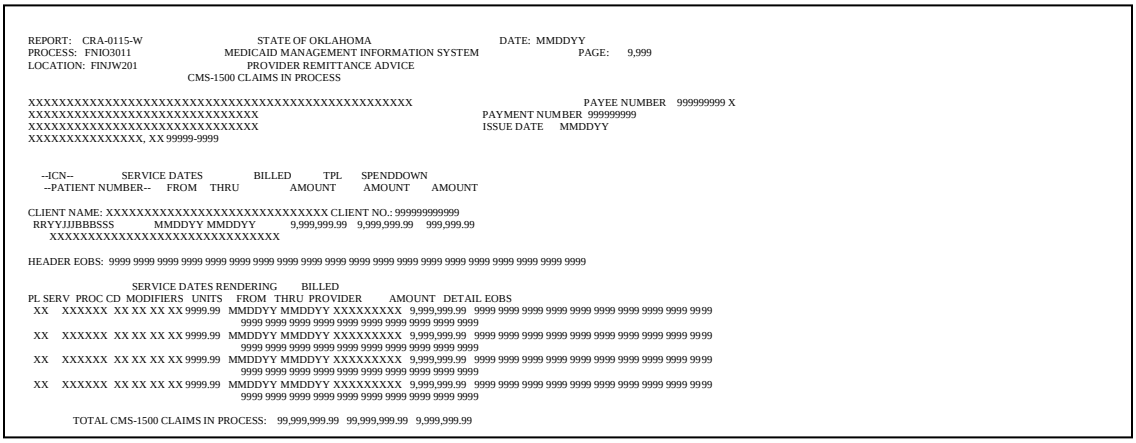
```
REPORT:    CRA-0000-W                    STATE OF OKLAHOMA                          DATE:  MMDDYY
PROCESS:   FNIO3011               MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:      9,999
LOCATION:  FINJW201                   PROVIDER REMITTANCE ADVICE
                              PROVIDER BANNER MESSAGES


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                PAYEE NUMBER    999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          ISSUE DATE     MMDDYY
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX 99999-9999


THIS IS A TEST OF RA BANNER MAINTENANCE BY CLAIM TYPE.
TEXT REGARDING PROVIDER SPECIFIC INFORMATION COULD BE FOUND IN THIS AREA.
```

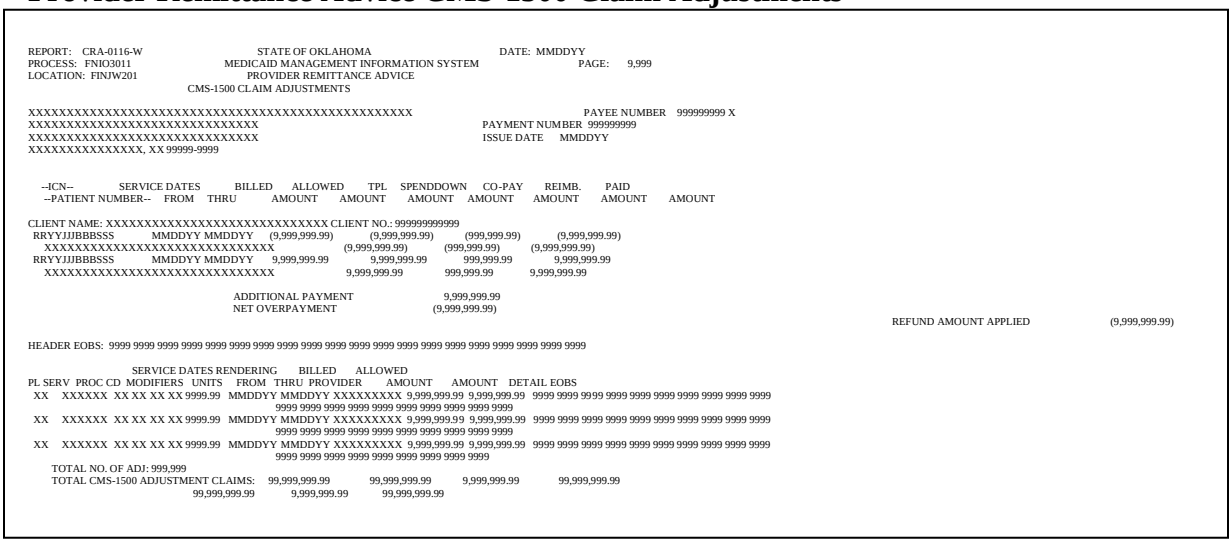
Provider Remittance Advice CMS-1500 Claims Paid Example

```
REPORT:    CRA-0113-W                    STATE OF OKLAHOMA                          DATE:  MMDDYY
PROCESS:   FNIO3011               MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:      9,999
LOCATION:  FINJW201                   PROVIDER REMITTANCE ADVICE
                              CMS-1500 CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                PAYEE NUMBER    999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYMENT NUMBER  999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          ISSUE DATE     MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


   --ICN--          SERVICE DATES        BILLED      ALLOWED       TPL    SPENDDOWN     CO-PAY      REIMB.       PAID
    --PATIENT NUMBER--    FROM    THRU          AMOUNT       AMOUNT       AMOUNT    AMOUNT      AMOUNT       AMOUNT       AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS          MMDDYY MMDDYY      9,999,999.99            9,999,999.99          999,999.99            9,999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            9,999,999.99            999,999.99         9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                             SERVICE DATES RENDERING     BILLED       ALLOWED
PL SERV  PROC CD  MODIFIERS   UNITS     FROM   THRU  PROVIDER      AMOUNT       AMOUNT       DETAIL EOBS
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999  9999 9999 9999
                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999  9999 9999 9999
                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999  9999 9999 9999
                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999  9999 9999 9999
                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                        9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

      TOTAL CMS-1500 CLAIMS PAID:      99,999,999.99          99,999,999.99          9,999,999.99           99,999,999.99
                                   99,999,999.99          9,999,999.99          99,999,999.99
```

Provider Remittance Advice CMS-1500 Claims Denied Example

```
REPORT:    CRA-0114-W                    STATE OF OKLAHOMA                          DATE:  MMDDYY
PROCESS:   FNIO3011               MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:      9,999
LOCATION:  FINJW201                   PROVIDER REMITTANCE ADVICE
                              CMS-1500 CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                PAYEE NUMBER    999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYMENT NUMBER  999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          ISSUE DATE     MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


   --ICN--            SERVICE DATES            BILLED        TPL      SPENDDOWN
    --PATIENT NUMBER--     FROM    THRU              AMOUNT        AMOUNT       AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
 RRYYJJJBBBSSS           MMDDYY MMDDYY          9,999,999.99   9,999,999.99    999,999.99
      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                             SERVICE DATES RENDERING        BILLED
PL SERV  PROC CD  MODIFIERS   UNITS     FROM   THRU  PROVIDER         AMOUNT   DETAIL EOBS
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

              TOTAL CMS-1500 CLAIMS DENIED:    99,999,999.99   99,999,999.99   9,999,999.99
```





Provider Remittance Advice CMS-1500 Claims In Process

```
REPORT:    CRA-0115-W                        STATE OF OKLAHOMA                          DATE:  MMDDYY
PROCESS:   FNIO3011                   MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:      9,999
LOCATION:  FINJW201                          PROVIDER REMITTANCE ADVICE
                                      CMS-1500 CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              PAYEE NUMBER    999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                              PAYMENT NUMBER  999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                              ISSUE DATE      MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


   --ICN--           SERVICE DATES           BILLED        TPL      SPENDDOWN
   --PATIENT NUMBER--     FROM    THRU            AMOUNT        AMOUNT      AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
 RRYYJJJBBBSSS           MMDDYY MMDDYY          9,999,999.99   9,999,999.99    999,999.99
     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                          SERVICE DATES RENDERING        BILLED
PL SERV  PROC CD  MODIFIERS   UNITS     FROM   THRU  PROVIDER         AMOUNT   DETAIL EOBS
 XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

           TOTAL CMS-1500 CLAIMS IN PROCESS:    99,999,999.99   99,999,999.99   9,999,999.99
```

Provider Remittance Advice CMS-1500 Claim Adjustments

```
REPORT:    CRA-0116-W                        STATE OF OKLAHOMA                          DATE:  MMDDYY
PROCESS:   FNIO3011                   MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:      9,999
LOCATION:  FINJW201                          PROVIDER REMITTANCE ADVICE
                                      CMS-1500 CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              PAYEE NUMBER    999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                              PAYMENT NUMBER  999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                              ISSUE DATE      MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999


   --ICN--           SERVICE DATES         BILLED      ALLOWED       TPL    SPENDDOWN     CO-PAY       REIMB.       PAID
   --PATIENT NUMBER--     FROM    THRU          AMOUNT       AMOUNT       AMOUNT    AMOUNT      AMOUNT       AMOUNT       AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
 RRYYJJJBBBSSS          MMDDYY MMDDYY     (9,999,999.99)          (9,999,999.99)         (999,999.99)          (9,999,999.99)
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       (9,999,999.99)          (999,999.99)         (9,999,999.99)
 RRYYJJJBBBSSS          MMDDYY MMDDYY      9,999,999.99            9,999,999.99           999,999.99            9,999,999.99
    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        9,999,999.99            999,999.99           9,999,999.99

                                      ADDITIONAL PAYMENT                    9,999,999.99
                                      NET OVERPAYMENT                      (9,999,999.99)
                                                                                                              REFUND AMOUNT APPLIED                   (9,999,999.99)

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                          SERVICE DATES RENDERING       BILLED       ALLOWED
PL SERV  PROC CD  MODIFIERS   UNITS     FROM   THRU  PROVIDER        AMOUNT       AMOUNT   DETAIL EOBS
 XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XX    XXXXXX  XX XX XX XX 9999.99   MMDDYY MMDDYY XXXXXXXXX  9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                          9999 9999 9999 9999 9999 9999 9999 9999 9999
      TOTAL NO. OF ADJ: 999,999
      TOTAL CMS-1500 ADJUSTMENT CLAIMS:     99,999,999.99          99,999,999.99         9,999,999.99           99,999,999.99
                                 99,999,999.99          9,999,999.99          99,999,999.99
```

Provider Remittance Advice Summary

```
REPORT:   CRA-0148-W                    STATE OF OKLAHOMA                     DATE:  MMDDYY
PROCESS:  FNIO3011                MEDICAID MANAGEMENT INFORMATION SYSTEM                PAGE:  9,999
LOCATION: FINJW201                      PROVIDER REMITTANCE ADVICE
                                   SUMMARY

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              PAYEE       999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYMENT NUMBER   999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   ISSUE DATE       MMDDYY
XXXXXXXXXXXXXXX, XX 99999-9999
                    -------------------------CLAIMS DATA---------------------------

                         CURRENT      CURRENT      YEAR-TO-DATE   YEAR-TO-DATE
                         NUMBER       AMOUNT       NUMBER         AMOUNT
    CLAIMS PAID                 999,999   9,999,999.99   9,999,999   99,999,999.99
    CLAIM ADJUSTMENTS               999,999   9,999,999.99   9,999,999   99,999,999.99
      TOTAL CLAIMS PAYMENTS            999,999   9,999,999.99   9,999,999   99,999,999.99
    CLAIMS DENIED             999,999              9,999,999
    CLAIMS IN PROCESS           999,999              9,999,999
                       -----------------------EARNINGS DATA-----------------------
    PAYMENTS:
      REIMBURSEMENT AMOUNT                  9,999,999.99              99,999,999.99
      STATE SHARE AMOUNT                  (9,999,999.99)            (99,999,999.99)
                               -------------          ---------------
      CLAIMS PAYMENTS                   9,999,999.99              99,999,999.99

      CAPITATION PAYMENT†                  9,999,999.99              99,999,999.99
      SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)          9,999,999.99              99,999,999.99
      ACCOUNTS RECEIVABLE (OFFSETS):
        CLAIM SPECIFIC:
          CURRENT CYCLE                 (9,999,999.99)            (99,999,999.99)
          OUTSTANDING FROM PREVIOUS CYCLES         (9,999,999.99)            (99,999,999.99)
        NON-CLAIM SPECIFIC OFFSETS           (9,999,999.99)            (99,999,999.99)

      NET PAYMENT**                     9,999,999.99              99,999,999.99

    REFUNDS:
      CLAIM SPECIFIC ADJUSTMENT REFUNDS          (9,999,999.99)            (99,999,999.99)
      NON CLAIM SPECIFIC REFUNDS            (9,999,999.99)            (99,999,999.99)

    OTHER FINANCIAL:
      MANUAL PAYOUTS (NON-CLAIM SPECIFIC)          9,999,999.99              99,999,999.99
      VOIDS                         (9,999,999.99)            (99,999,999.99)

    NET EARNINGS                       9,999,999.99              99,999,999.99

    FICA WITHHELD                      9,999,999.99              99,999,999.99

**  NET PAYMENT AMOUNT HAS BEEN REDUCED.  LIEN PAYMENTS HAVE BEEN MADE TO THE FOLLOWING LIEN HOLDERS.
† CAPITATION PAYMENT FOR THE MONTH OF MM/YY.  PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR  ADDITIONAL DETAIL.
```

Explanation of Benefit Codes Example

```
REPORT:   CRA-0147-W      z          STATE OF OKLAHOMA                      DATE:  MMDDYY
PROCESS:  FNIO3011                MEDICAID MANAGEMENT INFORMATION SYSTEM          PAGE:  9,999
LOCATION: FINJW201                      PROVIDER REMITTANCE ADVICE
                                 EOB CODE DESCRIPTIONS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              PAYEE       999999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYMENT NUMBER   999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   ISSUE DATE       MMDDYY
XXXXXXXXXXXXXXX, XX  99999-9999

EOB CODE    DESCRIPTION

9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Chapter 17

Utilization Review

INTRODUCTION

Utilization review activities required by the OHCA are accomplished through a series of monitoring systems developed to ensure that services are reasonable, medically necessary and of optimum quality and quantity. Members and providers are subject to utilization review. Utilization control procedures safeguard against

- unnecessary care and services;
- inappropriate services and quality of care; and
- inappropriate payment.

UTILIZATION REVIEW FOCUS

Utilization review activities ensure the efficient and cost-effective administration of the OHCA by monitoring

- billing and coding practices ;
- medical necessity;
- level of care validations;
- quality of care;
- documentation;
- misuse;
- overuse;
- reasonableness of prior authorization (PA); and
- other administrative findings.

FEDERAL REGULATIONS

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found in 42 CFR 456 mandate that utilization review of the OHCA services provide methods and procedures to safeguard against unnecessary use of care and services.

These federal regulations also require that the OHCA be able to identify and, if warranted, refer cases of suspected fraud or abuse to the Medicaid Fraud Control Unit of the Office of the Oklahoma Attorney General for investigation and prosecution. Utilization review guards against unnecessary medical care and services, and ensures that payments are appropriate according to the coverage policies established by the OHCA.

UTILIZATION REVIEW MONITORING

The Surveillance and Utilization Review System (SURS) is used to help identify patterns of inappropriate care and services. Use of this system enables the OHCA to develop a comprehensive profile of any unusual pattern of practice and reveals suspected instances of fraud or abuse in the SoonerCare (Medicaid) program. The Utilization Review program is a useful tool in detecting the existence of any potential defects in the level of care or services provided under the SoonerCare program.

SECTION A: PROVIDER UTILIZATION REVIEW

FRAUD DEFINED

Fraud is an intentional deception or misrepresentation made by the provider or member, which could result in an unauthorized benefit such as an improper payment to a SoonerCare provider. Some examples of fraud are

- altering a member's medical records to generate fraudulent payments;
- billing for services or supplies not rendered or provided;
- soliciting, offering or receiving a kickback, bribe or rebate; or
- submitting claim forms inappropriately altered to obtain higher reimbursement.

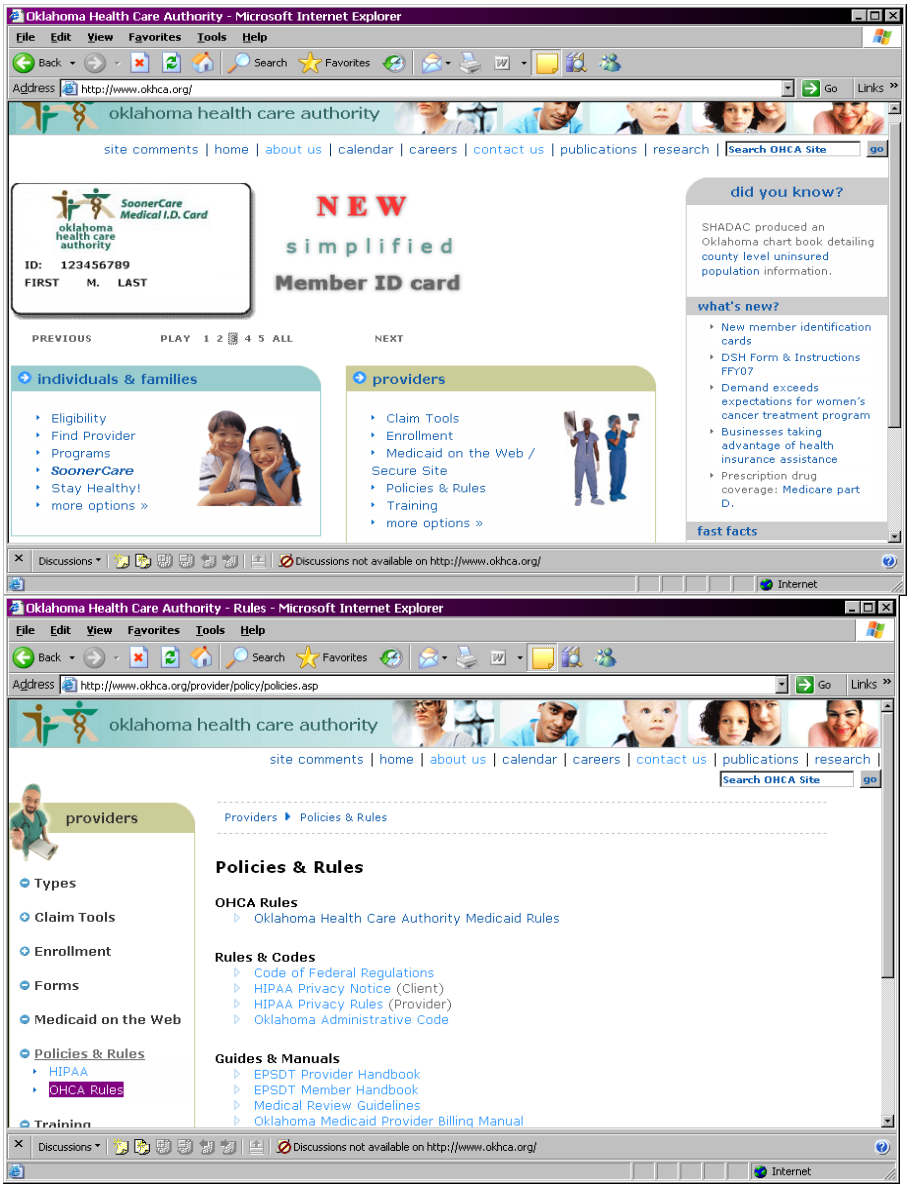
ABUSE DEFINED

The term abuse describes incidents or practices of the OHCA providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices can result in unnecessary costs to the OHCA, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary. Some examples of abuse are

- billing and receiving payment from an OHCA member for the difference between the provider charge and the OHCA reimbursement for the service;
- submitting claims for services not medically necessary in relation to a member's diagnosis;
- excessive charges for services or supplies; or
- violation of any of the provisions of the provider agreement.

RECORD RETENTION

For more information on record retention, go to http://www.okhca.org, select the (Providers Section) More Options (see Screen Sample 16.1) and select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens and scroll down to Sections 317:30-3-4.1 and 317:30-3-15. Specific provider policy sections may be referenced for any additional requests.



Screen Sample 16.1

SECTION B: MEMBER UTILIZATION REVIEW

When member utilization review identifies a member who might be using SoonerCare services more extensively than his/her peers, the member can be placed on a Lock-In/Restricted Services Program. Visit http://www.okhca.org, select the (Providers Section) More Options (see Screen Sample 16.1) and select the OHCA Rules link under Policies & Rules. Select the Chapter 30 link once the page opens and scroll down to Section 317:30-3-14 to obtain more information on member lock-in.

IDENTIFICATION OF LOCK-IN MEMBERS

Restricted data are available from the following areas:

- Eligibility Verification System (EVS)/Automated Voice Response (AVR) at 800-767-3949 or 405-840-0650.
- Swipe card device.
- The Medicaid on the Web secure site.

If the member is restricted, the EVS/AVR, Medicaid on the Web or swipe-card device will list those restrictions. In addition to the restricted program guidelines, all other OHCA guidelines, such as prior authorization (PA) requirements, must be followed.

For questions about the Lock-In program, please contact the pharmacy help desk at 800 522-0114, option 4.The PHARM-16 (Pharmacy Lock-In Referral form) is located on the Pharmacy Forms page at http://www.okhca.org/provider/types/pharmacy/pharmacy_forms.asp

SECTION C: UTILIZATION REVIEW TRENDS

Fraud and abuse of the Soonercare system costs taxpayers millions of dollars each year. Responsible Oklahomans need to work together to prevent fraud and abuse, and to ensure that the SoonerCare funds available are directed to those who truly deserve them.

The state relies on the health care provider community to be active participants in detecting, and deterring SoonerCare abuse and fraud. If abusive or fraudulent activities are suspected, providers are encouraged to contact one of the following offices:

Member Fraud
Department of Health and Human Services
The Office of Inspector General
Oklahoma City HOTLINE 800-784-5887
Tulsa HOTLINE 800-797-1780

Office of Inspector General (OIG) National Hotline
1-800-HHS-TIPS (800-447-8477)

Office of Inspector General
Department of Health and Human Services
Medicaid Fraud Control Unit
Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Provider Fraud
Office of Attorney General
2300 North Lincoln Blvd., Suite 112
Oklahoma City, OK 73105
Phone: 405-521-4274
Tulsa Office: 918-581-2885

Surveillance Utilization Review Subsystem (SURS)
Oklahoma Health Care Authority
4545 North Lincoln Blvd., Suite 124
Oklahoma City, OK 73105-3400
Phone: 405-522-7421
FAX: 405-530-3246

SECTION D: ADMINISTRATIVE REVIEW AND APPEAL PROCESS

CRIMINAL PENALTIES

Section 1909 of the Social Security Act provides criminal penalties for providers or members who make false statements or representations or intentionally conceal facts in order to receive payments or benefits. These penalties apply to kickbacks, bribes and rebates to refer or induce purchase of SoonerCare compensable services. The penalties also apply to individuals who knowingly and willfully charge members the difference between billed amounts and the amount allowed by SoonerCare.

BASIS FOR SANCTIONS

The OHCA may sanction a medical provider who has an agreement with the OHCA. To obtain more information on sanctions, go to http://www.okhca.org., select the (Providers Section) More Options (see Screen Sample 16.1), scroll down and select the OHCA Rules link under Policies & Rules. Select the Chapter 30 link once the page opens and scroll down to sections 317:30-3-18, and 317:30-3-19.

APPEALS PROCEDURES (EXCLUDING NURSING HOMES AND HOSPITALS)

To obtain more information on appeals, go to http://www.okhca.org., select the (Providers Section) More Options (see Screen Sample 16.1), scroll down and select the OHCA Rules link under Policies & Rules. Select the Chapter 30 link once the page opens and scroll down to Section 317:30-3-20; 317:2-1-2.2 (Members appeals); 317:2-1-2.3 (other grievances).

APPEALS PROCEDURES FOR LONG TERM CARE NURSING FACILITIES

To obtain more information on long term care facility appeals, go to http://www.okhca.org, select the (Providers Section) More Options (see Screen Sample 16.1), scroll down and select the OHCA Rules link under Policies and Rules. Select the Chapter 30 link once the page opens and scroll down to Section 317:30-3-21.

Chapter 18

Quality Assurance And Improvement

INTRODUCTION

The Quality Assurance and Improvement Department of the Oklahoma Health Care Authority (OHCA) coordinates the quality assurance evaluation and improvement processes for all OHCA medical programs. These functions are accomplished through ongoing monitoring and evaluation of SoonerCare services and implementation of improvement initiatives to help ensure that SoonerCare beneficiaries receive appropriate and high quality health care. This unit also coordinates the activities of the agency Quality Assurance Committee and provides technical support in developing and reporting federally required quality assurance/improvement activities of the agency. In addition, the Quality Assurance and Improvement Department maintains the Oklahoma Medicaid Management Information System (OKMMIS) reference file of procedure and diagnosis codes for each SoonerCare program.

The Quality Assurance and Improvement requirements of the OHCA are completed through a variety of monitoring and evaluation activities to ensure that the health care services provided to SoonerCare members meet quality standards as well as program requirements. Quality Assurance and Improvement activities include

- monitoring of utilization for the various SoonerCare programs;
- on-site provider audits for the evaluation of contract compliance;
- investigation of member and provider complaints;
- development and monitoring of quality improvement studies; and
- ongoing evaluation and maintenance of the integrity of the OKMMIS system.

SECTION A: PROVIDER UTILIZATION REVIEW

State Medicaid agencies are required by federal regulations to provide methods and procedures to safeguard against unnecessary utilization of care and services, and to assure "efficiency, economy and quality of care." To meet the requirements of the federal regulations, the OHCA contracts with a Quality Improvement Organization (QIO) to conduct medical and utilization reviews. APS Healthcare Midwest serves as the contracted QIO for the OHCA. The Quality Assurance and Improvement department provides oversight of the QIO contract and works with the contracted QIO.

Federal regulations and OHCA rules state that some Medicaid services are subject to utilization review by an external organization under contract with the OHCA. The QIO conducts a medical hospital random sample review on services provided to SoonerCare beneficiaries in the SoonerCare Traditional fee-for-service program. The purpose of the inpatient hospital utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to SoonerCare beneficiaries. Federal regulations require medical services and/or records to be reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay by the contracted organization. In addition to inpatient review, The QIO conducts a random sample review of hospital outpatient observation services to ensure that these services meet specified guidelines.

The OHCA rules state that the QIO conducts the administrative process for the providers it reviews. The process conducted by the QIO is the only administrative remedy available to providers and the decision issued by the QIO is considered by the OHCA to be a final administrative decision. The final determination is not appealable to the OHCA for any further administrative review. Following the final determination on a utilization review, the OHCA will recoup the monies paid to the provider(s) associated with the review.

All inpatient and outpatient observation services are subject to QIO post-payment utilization review. These reviews are based on illness severity and treatment intensity. Hospitals and providers have the opportunity to present any and all documentation available to support the medical necessity of the provided services. If a denial determination is made by the QIO, a notice is issued to the facility, and attending physician advising them of the decision and the time frame for submitting a reconsideration request. Additional information submitted with the reconsideration request will be reviewed by the QIO and a final decision on the reconsideration will be made by the QIO within the specified time frame. The provider(s) will be notified of that decision. Once that process is finalized, the QIO notifies the OHCA of the decision. If the initial decision is upheld, the claim is processed for recoupment. If the review is denied and a refund from the hospital and physician is required, the SoonerCare member may not be billed for the denied services.

SECTION B: ON-SITE PROVIDER AUDITS

The staff of the OHCA Quality Assurance and Improvement department conducts on-site provider audits on a routine basis for all SoonerCare Choice primary care providers. The purpose of

these reviews is to assess contract compliance, and provide education to providers on the SoonerCare program, contract requirements, billing, EPSDT requirements, chart documentation and other topics. The unit staff provides information related to current performance improvement initiatives of the organization and referral assistance to other departments within the agency. The compliance team consists of a compliance analyst and a nurse who collaborates the required review items. Prior to the review, a departmental staff member notifies the office staff and provider of the upcoming review. Once a review date is scheduled, the staff mails a copy of the audit tool to the provider, including information about the documents requested for the review. A list of the requested medical records will be submitted to the provider prior to the review. Following the on-site review, the provider receives a written audit report that details the findings and any required follow-up action. The QA/QI staff will work with the provider to comply with any required action. The compliance team works in partnership with the contracted provider and other OHCA staff and is available to assist with improvement activities.

SECTION C: MEMBER OR PROVIDER COMPLAINTS

Quality Assurance and Improvement staff members conduct reviews and follow-ups for member's and provider's potential quality of care issues. These cases are identified by OHCA staff and are referred to the Quality Assurance and Improvement department for review. When a referral is received, it is often necessary to request records from provider(s) identified in the actual referral or through an analysis of claims related to the complaint.

Cases may also be identified by the contracted QIO through completion of activities associated with contract requirements. When identified, medical records and/or additional information from the identified provider are requested for completing the review of potential issues. OHCA staff may also refer potential quality of care cases to the QIO for review and follow-up.

SECTION D: QUALITY IMPROVEMENT STUDIES/PROJECTS

The OHCA conducts ongoing quality improvement studies. Some of these studies are ad hoc in nature and developed in response to an identified area of focus for improvement. Others are conducted on a routine and ongoing basis. In addition to the studies conducted in the unit, the OHCA conducts studies through its contract with its QIO.

A partial listing of studies conducted by OHCA staff and/or in collaboration with its QIO include

- EPSDT screenings;
- comprehensive diabetic management;
- ER utilization;
- cervical cancer screenings;
- breast cancer screenings;
- appropriate medications for the treatment of asthma;
- prenatal care;
- service utilization; and
- member satisfaction surveys.

The completion of some studies requires review of the medical records associated with the SoonerCare members selected in the sample. For those studies, a request for a copy of each medical record needed for review will be made by staff from the contracted QIO and/or by OHCA staff. Providers are required to send requested records within the request's specified time frame. The Quality Assurance and Improvement Department encourages any questions concerning the medical record requests.

The Quality Assurance and Improvement Department also develops and monitors quality improvement initiatives. Current initiatives include

- emergency room utilization provider profiling;
- emergency room utilization member outreach;
- adult diabetes care;
- EPSDT screenings;
- childhood immunizations; and
- adolescent immunizations.

The Quality Assurance and Improvement Department is currently developing additional provider profiles, which include breast cancer screening, cervical cancer screening and EPSDT screening.

In addition to internal improvement activities, the OHCA collaborates with external organizations in research and quality improvement initiatives. Department staff members are active project participants with the State Task Force to Reduce Health Care Disparities, the Child Death Review Board, the Center for Health Care Strategies and the Oklahoma State Department of Health. Departmental staff members also provide data and research support for multiple quality-related projects.

SECTION E: SYSTEM INTEGRITY

The Quality Assurance and Improvement Department maintains the OKMMIS Reference File, which includes diagnosis, procedure

and revenue codes, and program specifications for claim processing. The department is also responsible for maintenance of the claims editing program, which is an integral part of the processing of physician claim form 1500. The staff members monitor and update code changes, existing policy, and policy changes to evaluate the impact of changes to the reference file and claims editing program. The department also makes recommendations for policy changes and/or new policy in response to program changes as well as changes throughout the health care industry.

Chapter 19
Forms

INTRODUCTION

Included in this chapter are copies of the forms mentioned in this manual. OHCA forms can also be obtained on the OHCA Web site at http://www.ohca.state.ok.us/provider/billing/forms/.

Form	Name
Pharm-1	Drug Claim Form
Pharm-2	Compound Prescription Drug Claim
Pharm -3	Pharmacy Paid Claim Adjustment Request
Pharm-4	Universal Petition for Medication Authorization
Pharm-6	Petition for Tuberculosis-Related Therapy Authorization
Pharm-7	Petition for Synagis Authorization
Pharm-8	Medication Therapy Management Services Prior Authorization Request
Pharm-9	Medication Therapy Management Services Member Referral Form
Pharm-11	Brand Name Drug Override Request
Pharm-14	Statement of Medical Necessity for Xolair
Pharm-6	Petition for Tuberculosis-Related Therapy Authorization
Pharm-16	Pharmacy Lock-in Referral
HCA-3	Elective Sterilization Consent
HCA-3A	Hysterectomy Acknowledgement
HCA-3B	Certificate for Abortion
HCA-12A	Prior Authorization Medical Request Form
HCA-12B	Prior Authorization Dental Request Form
HCA-13	Electronic Claim Paper Attachment Form Cover Sheet
HCA-13A	Prior Authorization Attachment Form Cover Sheet
HCA-14	UB-92 and Inpatient/Outpatient Crossover Adjustment Form
HCA-15	Paid Claim Adjustment Request for Crossover Part B, Dental, and 1500
HCA-17	Inquiry Response Form
HCA-18	Request for Duplicate Provider Remittance Statement (beyond 60 days)
HCA-20 English	Request to Release SoonerCare Records
HCA-20 Spanish	Autorización para reveler el expendiente medico
HCA-24	Care Management Referral
HCA-28	Professional Services Medicare-Medicaid Crossover Invoice
UB-04	Institutional Claim Form
1500	Professional Claim Form

ADA 2002	Dental Claim Form
SC-10	SoonerCare Choice Referral Form with Guidelines and instructions
SC-11	SoonerCare Choice Provider Change Request

[redacted]

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Drug Claim Form

PLEASE PRINT CLEARLY

Provider Number Loc	Telephone Number	Total Amount Billed
01	02	03

0	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
1	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
2	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
3	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
4	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
5	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
6	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
7	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	
8	PATIENT'S NAME: LAST, FIRST 04	CLIENT NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.H.PAT. 09	BRAND 10	REFILL 11	
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17	CHARGE 18		3RD PTY PAID 19	

Provider's Name and Address

18

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

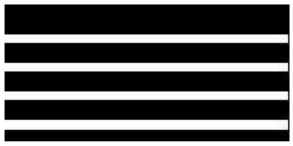
Signature of Provider or Representative

19 _____

Date Billed

20 _____

MAIL COMPLETED CLAIM FORM TO:
EDS
P.O. Box 18650
Oklahoma City, OK 73154



STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
Compound Prescription Drug Claim

PLEASE PRINT CLEARLY

Provider Number 1	Loc	Telephone Number 2						
PATIENT'S NAME: LAST, FIRST 3		CLIENT NO. 4	PRESCRIBER'S I.D. NUMBER 5	EMERG 6	PREG 7	N.H. PAT 8	BRAND 9	REFILL 10

PRESCRIPTION NUMBER 11	DATE PRESCRIBED 12	DATE DISPENSED 13	LOCAL USE ONLY 14	DAYS 15	CHARGE 16	3RD PARTY PAID 17

LINE NUMBER	NDC NUMBER 21	DESCRIPTION OF INGREDIENT 22	QUANTITY 23
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Provider's Name and Address
18

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of Provider or Representative
19

Date Billed
20

MAIL COMPLETED CLAIM FORM TO:
EDS
P.O. Box 18650
Oklahoma City, OK 73154

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY PAID CLAIM ADJUSTMENT REQUEST

List no more than 10 claims per request

(1) PROVIDER NUMBER PROVIDER NAME/ADDRESS PHONE NUMBER: CONTACT PERSON:	Mail completed adjustment request forms to: OHCA – Adjustments 4545 N. Lincoln Blvd., Suite 124 Oklahoma City, OK 73105 Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299	
	(2) MEDICAID PROGRAM ☐ Fee for Service ☐ SoonerCare	(3) TYPE OF ADJUSTMENT ☐ Underpayment Adjustment ☐ Overpayment Adjustment (Deduct from future payments) ☐ Refund Adjustment (Check attached) Check number:

Complete blocks 4 – 10 for each Pharmacy claim to be adjusted. If all information is not complete, this request will be returned.

(4) CLAIM NUMBER (ICN)	(5) CLIENT ID NO.	(6) DATE DISPENSED	(7) AMOUNT PAID	(8) CURRENT INFORMATION	(9) CORRECTED INFORMATION	(10) EXPLANATION OF ADJUSTMENT

(11) SIGNATURE: _____ (12) DATE: _____

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY PAID CLAIM ADJUSTMENT REQUEST INSTRUCTIONS

A completed adjustment request form is required for each claim you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

1	**PROVIDER NUMBER**	Enter your 9 digit billing provider number and 1 character service location
	PROVIDER NAME/ADDRESS	Enter your current billing name and address
	PHONE NUMBER	Enter phone number of contact person
	CONTACT NAME	Enter a contact name
2	**PROGRAM**	Check the appropriate box for the program to which the claim to be adjusted is associated
3	**TYPE OF ADJUSTMENT**	Check the appropriate box for the type of adjustment you are requesting: * Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim's data which will result in no net change in payment. * Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion or the entire amount of the claim.) * Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)
4	**CLAIM NUMBER (ICN)**	Enter the Internal Control Number of the claim you wish to adjust. This can be found on the Remittance Advice. (use the most current ICN for the claim to be adjusted.)
5	**CLIENT ID NO.**	Enter the recipient's 12 digit identification number
6	**DATE DISPENSED**	Enter the Dispense Date as billed on the claim
7	**AMOUNT PAID**	Enter the Paid Amount of the claim to be adjusted
8	**CURRENT INFO**	Enter the information as stated on the current claim that is to be adjusted
9	**CORRECTED INFO**	Enter the corrected information for the claim
10	**EXPLANATION**	Give a clear explanation of the requested adjustment or refund (i.e. submitted incorrect units or service, incorrect NDC, private insurance paid)
11	**SIGNATURE**	Enter signature of appropriate person (physician, billing clerk, etc. – not required)
12	**DATE**	Enter the date you are submitting this request (Required)

61725

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
UNIVERSAL PETITION FOR MEDICATION AUTHORIZATION

Patient Name: _____ *Birthdate:* ☐☐ / ☐☐ / ☐☐☐☐

UCI: ☐☐☐☐☐☐☐☐☐☐

DosageChange ☐ *DC Previous Petition* ☐

NewPrescription ☐ *PharmacyChange* ☐

TO BE COMPLETED BY DISPENSING PHARMACY

Dispensing Pharmacy Name: _____

Dispensing Pharmacy OHCA Provider Number: ☐☐☐☐☐☐☐☐☐☐

Dispensing Pharmacy Phone Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

Dispensing Pharmacy Fax Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

NDC Number: ☐☐☐☐☐ - ☐☐☐☐ - ☐☐

Fill Date: _____

Monthly Quantity: _____

Medication: _____ *Strength:* _____ *Regimen:* _____

Provider Prescriber Number ☐☐☐☐☐☐☐

Prescribing Phone Number (☐☐☐) ☐☐☐ - ☐☐☐☐

Prescribing Name (Printed): _____

Pharmacist Name (Signed): _____ *Date:* _____

TO BE COMPLETED BY APPROPRIATE HEALTH CARE PROVIDER

Diagnosis, Disease State (ICD-9/Description): ☐☐☐ - ☐☐ _____

_____

Previous Tier-1 trials and/or OTC's Trial-list name, dosage, dates and reason for failure: _____

_____

Schedule II Drugs Require Physician Signature

Prescribing Name (Signed): _____ *Date:* _____

Please Provide the Information Requested and Return to:
UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS
PRODUCT BASED PRIOR AUTHORIZATION UNIT

Phone (405) 522-6205 Opt 4
Toll Free 1-800-522-0114 Opt 4

FAX (405) 271-4014
Toll Free 1-800-224-4014

OKLA HCA Issued 10-30-07 Pharm-4

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

PETITION FOR TUBERCULOSIS (TB) RELATED THERAPY AUTHORIZATION

ONLY ONE INDIVIDUAL PER PETITION

Client Name: _____ *Birthdate:* ☐☐ / ☐☐ / ☐☐☐☐

UCI: ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY DISPENSING PHARMACY

Dispensing Pharmacy Name: _____

Dispensing Pharmacy OHCA Provider Number: ☐☐☐☐☐☐☐☐☐☐

Dispensing Pharmacy Phone Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

Dispensing Pharmacy Fax Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

NDC Number: ☐☐☐☐☐ - ☐☐☐☐ - ☐☐

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Medication Name: _____

Dosage: _____ *Qty Prescribed:* _____

Has the patient been approved for TB benefits? *Yes* _____ *No* _____

Please list supporting information that associates this therapy with the patient's primary diagnosis of TB (use additional sheets if necessary):

_____

_____

_____

_____

Intent of the Program is to work with Health Care Providers. Therefore, if there are circumstances relating to the treatment of the individual that would warrant additional consideration, please provide appropriate comments on an additional page.

Signature of Prescribing Physician: _____

Name of Prescribing Physician (Please Print): _____

Prescribing Physician's Phone Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

Please Provide the Information Requested and Return to:
UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS
PRODUCT BASED PRIOR AUTHORIZATION UNIT

Phone (405) 522-6205 Opt 4
Toll Free 1-800-522-0114 Opt 4

FAX (405) 271-4014
Toll Free 1-800-224-4014

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PETITION FOR SYNAGIS AUTHORIZATION

Member Name: _____ Sex: _____ UCI: _____

Date of birth: _____ Gestational age: _____ weeks Current Age: _____ Months

Birth Weight: _____ kg Current Weight: _____ kg Date Recorded: _____

☐ Dose received in hospital. Date: _____

DRUG INFORMATION: 15 mg/kg IM. Only those doses that require greater than a vial's dose +10% may use the next vial size or an additional vial (e.g. 1-55 mg = 50 mg vial, 56-110 mg = 100 mg vial). The maximum duration of therapy is 6 doses with 1 dose given every 30 days.

Physician billing ☐ CPT code 90378 (50 mg/unit)

Pharmacy billing ☐ 50 mg/0.5 ml: NDC: **60574411401** ☐ 100 mg/ml: NDC: **60574411301**

PROVIDER INFORMATION: ☐ **Pharmacy** ☐ **Physician**

Provider _____ OHCA Provider Billing ID# _____

Provider Phone: _____ Provider Fax: _____

Prescriber _____ OHCA Prescriber ID# _____

CRITERIA

Member must be included in one of the following age groups at the beginning of the RSV season:

- ☐ Infants and children less than 24 months old with Chronic Lung Disease (CLD) (formerly broncho-pulmonary dysplasia) who have required medical treatment (O_2, bronchodilator, diuretic, or corticosteroid therapy) for CLD in the 6 months prior to RSV season. Treatment/date received: _____
- ☐ Infants less than 12 months of age, born at 28 weeks gestation or earlier
- ☐ Infants less than 6 months of age, born at 29-31 weeks gestation.
- ☐ Infants, up to 6 months old, born at 32-35 weeks gestation, who have 2 or more of the following risk factors:
  - ☐ Child care attendance
  - ☐ School-aged siblings
  - ☐ Exposure to environmental air pollutants (Tobacco smoke exposure is NOT considered a risk factor since this can be controlled by the family) Describe: _____
  - ☐ Congenital abnormalities of the airway
  - ☐ Severe neuromuscular disease
- ☐ Children up to 24 months old with hemodynamically significant cyanotic and acyanotic congenital heart disease.
- ☐ Infants up to 12 months old with moderate to severe pulmonary hypertension, cyanotic heart disease, or those on medications to control congestive heart failure.

Additional Information: _____

_____

Prescriber Signature (*Required*) _____ Date _____

Phone: _____ Fax: _____

Please Provide the Information Requested and Return to:
UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS
PRODUCT BASED PRIOR AUTHORIZATION UNIT

Phone (405) 522-6205 Opt 4
Toll Free 1-800-522-0114 Opt 4

FAX (405) 271-4014
Toll Free 1-800-224-4014

STATE OF OKLAHOMA - OKLAHOMA HEALTH CARE AUTHORITY
MEDICATION THERAPY MANAGEMENT SERVICES
PRIOR AUTHORIZATION REQUEST FORM

Type of PA Requested: ☐ Script Limit Exceeded ☐ Brand Limit Exceeded

Client Name: _____ Birthdate: ☐☐ / ☐☐ / ☐☐☐☐

Client ID Number: ☐☐☐☐☐☐☐☐☐

Is this a waiver? If NO, please complete the Universal Petition for Medication Authorization (HCA-19)

TO BE COMPLETED BY DISPENSING PHARMACY

Dispensing Pharmacy Name: _____

Dispensing Pharmacy OHCA Provider Number: ☐☐☐☐☐☐☐☐☐☐

Dispensing Pharmacy Phone Number: (☐☐☐) ☐☐☐-☐☐☐☐

Dispensing Pharmacy Fax Number: (☐☐☐) ☐☐☐-☐☐☐☐

NDC Requested: ☐☐☐☐☐-☐☐☐☐-☐☐ Fill Date Requested: _____

Medication: _____ Strength: _____ Regimen: _____

Physician Prescriber Number: ☐☐☐☐☐☐☐ Physician Phone Number: (☐☐☐) ☐☐☐-☐☐☐☐

Physician Name (Printed): _____

Pharmacist Name (Printed): _____ Date: _____

TO BE COMPLETED BY APPROPRIATE HEALTH CARE PROVIDER

Diagnosis, Disease State (ICD-9 and/or description): ☐☐☐-☐☐ _____

_____

_____

Previous medication trials (including name, dosage, dates and reason for failure): _____

_____

_____

***Schedule II Drugs Require Physician Signature**

Physician Name (Signed): _____ Date: _____

Please Provide the Information Requested and Return to:
UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS
MEDICATION THERAPY MANAGEMENT SERVICES

Phone (405) 271-6020
Toll Free 1-866-837-6450

FAX (405) 271-6002
Toll Free 1-866-335-3331

OKLA HCA Revised 10-30-07 Pharm-8

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICATION THERAPY MANAGEMENT SERVICES—MEMBER REFERRAL FORM

PART 1 — WAIVER VERIFICATION

Is the member enrolled in an Oklahoma Medicaid waiver program? ☐ *Yes* ☐ *No*

IF NO, STOP HERE.—The member is not eligible for Medication Therapy Management Services.

(To check a member's waiver status, please contact the OHCA Pharmacy Help Desk at (800) 522-0114, option 4 or (405) 522-6205, option 4.)

PART 2 — MEMBER INFORMATION

Member Name: _____ *Member ID Number:* _____ *Date of Birth:* / /

Is the member known to be allergic to any medications? ☐ *Yes* ☐ *No*

If yes, please list: _____

PART 3—MEDICATION PROFILE

Complete all information for each line. Include all medications the member is taking, including known OTC products.

	Medication Name / Strength	*Regimen*	*Prescribing Physician*	*Diagnosis*
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				

(If necessary, additional pages may be attached. Please include member name, ID number, and date of birth on all pages submitted.)

Please provide the requested information and return to:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Medication Therapy Management Services

Fax
OKC Metro: (405) 271-6002
Toll Free: (866) 335-3331

Phone
OKC Metro: (405) 271-6020
Toll Free (866) 837-6450

Pharm-9

OKLA HCA
Revised 2-22-06

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Statement of Medical Necessity for Brand-Name Drug Override

Pharmacy Management Consultants
Prior Authorization Unit

Phone: 405-522-6205 Opt 4 or 1-800-522-0114 Opt 4
Fax: 405-271-4014 or 800-224-4014

After completing this form, please **fax** this form and any requested documentation to Pharmacy Management Consultants. Please make sure that the client's Medicaid ID Number is on every page faxed.

THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:

Patient's Name:	Patient's Medicaid Client ID Number:
Patient's Date of Birth:	Dispensing Pharmacy Phone Number: ( ) -
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number: ( ) -
Dispensing Pharmacy OHCA Provider Number:	Requested Drug Name & Strength:
Requested Drug NDC Number:	Requested Drug Monthly Quantity:
Requested Drug Dosing Regimen:	Requested Drug Fill Date:
Prescriber Name:	Medicaid Prescriber Number:
Prescriber Phone Number:	Prescriber Fax Number:

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:

Patient needs the requested brand-name drug rather than its FDA approved generic equivalent because:

- ❑ Patient experienced an adverse event while using the generic medication.
- ❑ The generic medication was not effective for the patient.
- ❑ Other (Please explain): _____

Please answer the following questions about what happened when the patient took the generic medication:

1. Generic medication taken (Give labeled strength, mfr/labeler, lot #, & exp. date, if known):

   _____

   _____

2. Dose, frequency, & route used:

   _____

3. Date(s) patient took the generic medication (give from/to or best estimate):

   _____

   _____

4. Diagnosis for use:

   _____

Statement of Medical Necessity for Brand-Name Drug Override

Patient's Medicaid Client ID Number (REQUIRED):

5. Description of adverse event or problem:

_____

_____

_____

_____

6. How long after beginning use of drug did the event occur?

_____

7. Outcomes attributed to adverse event caused by generic medication:

❑ Life-threatening ❑ Hospitalization – initial or prolonged ❑ Disability

❑ Intervention was required to prevent permanent impairment/damage

❑ Other: _____

8. Event abated after use stopped or dose reduced? ❑ Yes ❑ No ❑ Doesn't apply

If yes, how long after stopping or reducing dose of drug did event abate?

_____

9. Event reappeared after reintroduction? ❑ Yes ❑ No ❑ Doesn't apply

10. Concomitant medical products & therapy dates:_____

_____

_____

11. Relevant Tests/Laboratory Data, Including Dates:_____

_____

12. Other Relevant History, Including Preexisting Medical Conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.):

_____

_____

_____

13. Patient's drug/excipient allergies:

_____

14. Patient's Weight: _____

15. Patient's Height: _____

** Medicaid may request additional supporting documentation.**

Prescriber Signature: _____ Date: _____

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Statement of Medical Necessity for Xolair

Pharmacy Management Consultants
Prior Authorization Unit

Phone: 405-522-6205 Opt 4 or 1-800-522-0114 Opt 4
Fax: 405-271-4014 or 800-224-4014

After completing the request form please **fax** to Pharmacy Management Consultants to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN INFORMATION	CLIENT INFORMATION
Physician Name:	Client ID Number:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Compliance with all of the prior authorization criteria is a condition for payment for this drug by Oklahoma Medicaid.

All information must be provided and Oklahoma Medicaid may verify through further requested documentation and the client's drug history will be reviewed prior to approval.

1. **Detailed description of diagnosis:** _____
2. **Date diagnosed:** _____
3. **List daily medications and dose prescribed for the treatment of this diagnosis:**

   Drug/Dose: _____ **Drug/Dose:** _____

   Drug/Dose: _____ **Drug/Dose:** _____
4. **Was a spacer for inhaled medications used?** _____ **If 'No', why not?** _____
5. **Compliant on daily inhaled corticosteroids for a minimum of 3 months prior to request?** _____
6. **List frequency of: Exacerbations – Number** _____**Per**_____; **AND Nightly Symptoms -- Number** _____**Per**_____
7. **List place and dates of asthma related hospitalizations and/or ER visits in the past 6 months:** _____

   _____
8. **Patients weight:** _____**kg; Baseline IgE Level:** _____**IU/ml; Xolair Dose:** _____
9. **Asthma reaction due to food or peanut allergy?** _____**; Or List the perennial aeroallergen** _____
10. **Physician's specialty?** _____

The above format is to assist the physician to provide medical documentation that Oklahoma Medicaid needs to review this request.

This information should come directly from the prescriber and NOT the pharmacy provider.

**** Please provide copies of medical documentation supporting the information above.**

Physician Signature: _____ **Date:** _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY LOCK-IN REFERRAL FORM

LOCK-IN UNIT PHONE: 1-800-522-0114 opt 4 **LOCK-IN UNIT FAX: 1-866-335-3331**

This form is used for referring members with possible medication over utilization to the Lock-in program to evaluate the need for possible lock-in to one pharmacy.

Referral Information

Referral Source: [] Health Care Provider [] ER Department
[] Pharmacy [] Other: _____
[] Caseworker

Referral Name: _____ **Referral Phone**: _____
Date of Referral: _____

Member Information

Member Name: _____

Member ID: _____

Member DOB: _____

Reason for Referral

[] Multiple Pharmacies [] Multiple ER visits
[] Multiple Prescribers [] Concern for Member Safety
[] Other

Description of referral reason: _____

_____

_____

_____

_____

_____

State of Oklahoma
OKLAHOMA HEALTH CARE AUTHORITY

This form is provided to comply with 42 CFR §441.258
Formerly Okla. D.I.S.R.S. Issued 2-6-79

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (doctor or clinic)_____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (mm/dd/yyyy) _____ . I, _____ hereby consent of my own free will to be sterilized by (doctor) _____ by a method called _____ . My consent expires 180 days from that date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

Signature _____
Date _____

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter _____Date _____

STATEMENT OF PERSON OBTAINING CONSENT

Before (name of individual)_____ signed the consent form, I explained to him/her the nature of the sterilization operation _____ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of person obtaining consent Date

Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (name of individual)_____ on (date of sterilization)_____, I explained to him/her the nature of the sterilization operation (type of operation)_____ the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for alternative final paragraphs: Check the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph must be checked.

☐ 1. At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

☐ 2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery (Describe circumstances):

Physician _____

Date _____

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Acknowledgement of Receipt of Hysterectomy Information

The Form is provided to meet the 42 CFR §441.2455 (c)(1)(2) Sterilization by hysterectomy and OAC: 317:30-5-19 Hysterectomies

Patient Name: _____

Address: _____

_____

Telephone #: _____

OHCA/Medicaid #: _____

Physician: _____

Address: _____

_____

_____

* * *

Prior to surgery, I have been informed, both orally and in writing, that as a result of the hysterectomy, which is to be performed by the doctor named above, I will be permanently incapable of reproduction.

_____
Patient Signature

_____
Date

State of Oklahoma
OKLAHOMA HEALTH CARE AUTHORITY

CERTIFICATE FOR ABORTION

Patient Name: _____

Address: _____

_____

Telephone: _____

Physician: _____

Address: _____

_____

OHCA Provider #: _____

I certify that an abortion is necessary to save the life of the mother, or that the pregnancy is the result of an act of rape or incest.

_____
Physician Signature

_____
Date

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PRIOR AUTHORIZATION REQUEST

☐ Initial Request ☐ Additional Documentation
☐ Amended ☐ Re-consideration

Section I

Prescribing Physician No. _____

NPI/ZIP/ZIP+4/ CN1/Taxonomy _____

Physician Name _____

Phone ( ) _____

Signature _____ Date _____

Section II

Member RID _____

Member Name _____

DOB _____

Parent/Guardian _____

Address _____

City/State/Zip _____ Phone #: _____

Section III

Estimated Length of Treatment: _____ Diagnosis Code(s): _____

Physician's Prescription:

_____

_____

_____

Does Member receive: IFSP/Sooner Start ☐ IEP ☐ (Please attach a copy of IFSP or IEP, if applicable.) WIC ☐

Description: _____

_____

Section IV

Rendering Provider No. (Loc.) ( ) _____

NPI/ZIP/ZIP+4/ CN1/Taxonomy _____

Phone ( ) _____

Fax ( ) _____

Provider Name _____

Address _____

City/State/Zip _____

Section V

Date Span of Service: From _____ To _____

Assignment Code (select from below) _____

(01) Home Health	(08) Audiology	(17) Vision Care
(02) Hospital IP	(09) Speech	(21) PD Nursing
(03) Hospital OP	(12) DME	(37) Hospice
(04) Physician	(13) OT	(40) High Risk OB
(06) Transplant	(14) PT	

Section VI LINE ITEM	PROCEDURE CODE	MODIFIER	DESCRIPTION UNITS	TOTAL UNITS FOR DATE SPAN	BILLED CHARGES
A					
B					
C					
D					
E					
F					
G					
H					
I					
J					
K					
L					

Signature of Rendering Provider _____ Date _____

FORWARD TO: **EDS Attn: Prior Authorizations; 2401 NW 23rd St., Ste 11; Oklahoma City, OK 73107**
OR FAX: 405-702-9080 Toll Free: 1-866-574-4991

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PRIOR AUTHORIZATION DENTAL REQUEST

Section I - Must be completed by a Medicaid Provider.

Phone _____

Name _____

Address _____

City/State/Zip _____

Group Provider No. _____ ( )
(10-digit provider number and location are required)

Section II

Client ID No. _____

DOB _____

Name _____

Address _____

City/State/Zip _____

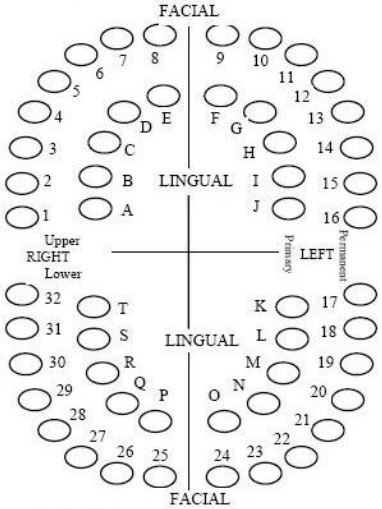
Section III LINE ITEM	PROCEDURE CODE	TOOTH #	SURFACE	LINE ITEM	PROCEDURE CODE	TOOTH #	SURFACE
A				F			
B				G			
C				H			
D				I			
E				J			

Section IV

1. Periodontics – Evaluate the periodontal condition:
   _____
   _____
   _____
   A. Indicate pocket depth for root planning (D4341): _____
   B. Indicate quadrant of diagram for gingival curettage (D4220): _____
2. Detailed description of condition or reason for the treatment:
   _____
   _____
   _____
3. Brief dental/medical history:
   _____
   _____
   _____

Section V

Does the Recipient have missing teeth?
Yes ○ No ○
If Yes, indicate missing teeth with an X.



When x-rays, photos or HLD form are required per criteria, please put them in an envelope and staple to this paper request and mark envelope "Confidential." Be sure the recipient's name and Medicaid number are included on the X-rays or photos.

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This form and any statement on my letterhead attached here to have been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Rendering Dentist _____ Date of Submission _____

Rendering Provider No. (Loc.) _____ (_____)

FORWARD TO: OHCA, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, OK 73105

oklahoma health care authority

Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet

Three fields below are required and must match claim.

1. Provider Number _____

2. Member ID Number _____

3. Attachment Control Number _____

Purpose:

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number that was used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Alphabetical and numeric are the only characters that should be used in ACN selection. Do not use dashes and spaces in ACNs.
4. Place this completed form on top of the attachment(s) for each electronic claim.
5. Mail to EDS, P.O. Box 18500 OKC, OK. 73107, fax 405-947-3394.

Note: Do not place another Fax Cover Sheet on top.

***This form is for use with Electronically filed Claims requiring attachments.**

Sender's Name:_____ Phone Number:_____

oklahoma health care authority

STATE OF OKLAHOMA
Oklahoma Health Care Authority
Prior Authorization Attachment Form
Cover Sheet

- ☐ Initial Request
- ☐ Amended
- ☐ Additional Documentation
- ☐ Re-consideration

Three fields below are required and must match the prior authorization request.

1. Provider Number or NPI/ZIP/ZIP+4/CN1

2. Client ID Number

3. Prior Authorization Number

Purpose:

This form is to be used when a prior authorization request requiring a paper attachment is being submitted electronically or by fax. Submission of this completed form along with the required attachments will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the Servicing Provider Number that was used for requesting the prior authorization.
2. In box 2, fill in the nine-digit client identification number that was submitted on the prior authorization request.
3. In box 3, fill in the ten-digit Prior Authorization Number (PAN) that the attachment corresponds with, or if a new request and prior authorization number is not available write *new* in this box. Make sure the PAN is clear and legible on the HCA-13A.
4. Place this completed form on top of the attachment(s) for each request.
5. Mail to: **EDS Attn: Prior Authorizations, 2401 NW 23rd, Ste 11, Oklahoma City, OK. 73107, OR Fax: 405-702-9080 Toll Free 1-866-574-4991.**

Note: Do not place another Fax Cover Sheet on top.

This form is for use with Prior Authorization requests requiring attachments.

Sender's Name:_____ Phone Number:_____

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
UB92 AND INPATIENT/OUTPATIENT CROSSOVER ADJUSTMENT REQUEST
Mail completed requests to: OHCA - Adjustments, 4545 N. Lincoln, Suite 124 Blvd., Oklahoma City, OK 73105

(1) PROVIDER NUMBER: PROVIDER NAME/ADDRESS: PHONE NUMBER: CONTACT PERSON:	(2) REASON FOR ADJUSTMENT: (Check appropriate Box) ☐ Change TPL Amt. ☐ Change Patient LIABILITY (Attach all EOMB's that apply) ☐ Offset or Refund of entire claim amount (check block 10) ☐ Change information as indicated in blocks 13-16 ☐ Medicare Adjustment (Attach all EOMB's that apply to this adjustment)

(3) CLAIM NUMBER (ICN)	(4) Client ID NO.	(5) DATE OF SERVICE From Thru
(6) Client NAME	(7) AMOUNT PAID	(8) REMITTANCE ADVICE DATE

(9) TYPE OF ADJUSTMENT	(10) CLAIM TYPE	(11) MEDICAID PROGRAM
☐ Underpayment Adjustment	☐ Inpatient	☐ Fee for Service
☐ Overpayment Adjustment (Deduct from future payments)	☐ Outpatient	☐ SoonerCare Choice
☐ Refund Adjustment (Check attached)	☐ Long Term Care	☐ SoonerCare Plus
Check number:	☐ Home Health	
	☐ Crossover	

(12) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) REV/PROC CODE.	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

17) SIGNATURE: _____ (18) DATE: _____

Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299

A completed adjustment request form is **required for each claim** you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

1	PROVIDER NUMBER	Enter your 9 digit billing provider number and 1 character service location
	PROVIDER NAME/ADDRESS	Enter your current billing name and address
	PHONE NUMBER	Enter phone number of the contact person
	CONTACT NAME	Enter a contact name
2	REASON FOR ADJUSTMENT	Check the appropriate box for the reason you are requesting an adjustment
3	CLAIM NUMBER (ICN)	Enter the Internal Control Number of the claim you wish to adjust. This can be found on the Remittance Advice. (Use the most current ICN for the claim to be adjusted.)
4	CLIENT ID NO.	Enter the recipient's 9 digit identification number
5	DATES OF SERVICE	Enter the From and Thru Dates of Service as billed on the claim
6	CLIENT NAME	Enter the First and Last Name of the Recipient
7	AMOUNT PAID	Enter the Paid Amount of the claim to be adjusted
8	REMITTANCE ADVICE DATE	Enter the date of your Remittance Advice on which the claim last paid
9	TYPE OF ADJUSTMENT	Check the appropriate box for the type of adjustment you are requesting: * Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim's data which will result in no net change in payment. * Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion of the claim or the entire amount of the claim.) * Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)
10	CLAIM TYPE	Check the appropriate box of the claim type to be adjusted.
11	PROGRAM	Check the appropriate box of the program to which the claim to be adjusted is associated.
12	EXPLANATION	Give a clear explanation for the requested adjustment or refund
13	REV/PROC CODE	Enter the number of the line that data is to be adjusted. If the adjusted data is not associated to a specific line on the claim, enter a zero (0) in this field
14	DESCRIPTION	Enter a brief description of the data that is to be corrected on the claim
15	CURRENT INFO	Enter the information as stated on the current claim that is to be adjusted
16	CORRECTED INFO	Enter the corrected information for the claim
17	SIGNATURE	Enter signature of appropriate person (physician, billing clerk, etc. – not required)
18	DATE	Enter the date you are submitting this request (Required)

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
CMS-1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST
Mail completed requests to: OHCA - Adjustments, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, OK 73105
Mail Refunds to: OHCA- Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299

1) PROVIDER NUMBER: PROVIDER NAME/ADDRESS: PHONE NUMBER: CONTACT PERSON:	(2) REASON FOR ADJUSTMENT: (Check appropriate Box) ☐ Change TPL Amt. (Attach all EOMB's that apply) ☐ Offset or Refund of entire claim amount (check block 10) ☐ Change information as indicated in blocks 13-16 ☐ Medicare Adjustment (Attach all EOMBs that apply to this adjustment)

(3) CLAIM NUMBER (ICN)	(4)CLIENT ID NO.	(5) DATE OF SERVICE From Thru
(6) CLIENT NAME	(7) AMOUNT PAID	(8) REMITTANCE ADVICE DATE

(9) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

(10) TYPE OF ADJUSTMENT	(11) CLAIM TYPE	(12) MEDICAID PROGRAM
☐ Underpayment Adjustment	☐ CMS-1500	☐ Fee for Service
☐ Overpayment Adjustment (Deduct from future payments)	☐ Dental	☐ SoonerCare
☐ Refund Adjustment (Check attached)	☐ Crossover	

Check number:

LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) LINE NO.	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

17) SIGNATURE: _____ (18) DATE: _____

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
CMS-1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST INSTRUCTIONS

A completed adjustment request form is **required for each claim** you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

1	PROVIDER NUMBER	Enter your 9 digit billing provider number and 1 character service location
	PROVIDER NAME/ADDRESS	Enter your current billing name and address
	PHONE NUMBER	Enter phone number of contact person
	CONTACT NAME	Enter a contact name
2	REASON FOR ADJUSTMENT	Check the appropriate box for the reason you are requesting an adjustment
3	CLAIM NUMBER (ICN)	Enter the Internal Control Number of the claim you wish to adjust. This can be found onthe Remittance Advice. (Use the most current ICN for the claim to be adjusted.)
4	CLIENT ID NO.	Enter the recipient's 9 digit identification number
5	DATES OF SERVICE	Enter the From and Thru Dates of Service as billed on the claim
6	CLIENT NAME	Enter the First and Last Name of the Recipient
7	AMOUNT PAID	Enter the Paid Amount of the claim to be adjusted
8	REMITTANCE ADVICE DATE	Enter the date of your Remittance Advice on which the claim last paid
9	EXPLANATION	Give a clear explanation for the requested adjustment or refund
10	TYPE OF ADJUSTMENT	Check the appropriate box for the type of adjustment you are requesting: * Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim's data which will result in no net change in payment. * Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion of the claim or the entire amount of the claim.) * Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)
11	CLAIM TYPE	Check the appropriate box of the claim type to be adjusted.
12	PROGRAM	Check the appropriate box of the program to which the claim to be adjusted is associated.
13	LINE NO.	Enter the number of the line that data is to be adjusted. If the adjusted data is not associated to a specific line on the claim, enter a zero (0) in this field
14	DESCRIPTION	Enter a brief description of the data that is to be corrected on the claim
15	CURRENT INFO	Enter the information as stated on the current claim that is to be adjusted
16	CORRECTED INFO	Enter the corrected information for the claim
17	SIGNATURE	Enter signature of appropriate person (physician, billing clerk, etc. – not required)
18	DATE	Enter the date you are submitting this request (Required)

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

CLAIM INQUIRY FORM

Attach a copy of your claim form and any applicable documentation. If you have previously sent a claim for review, please be sure to include additional documentation not previously sent to support your request. Please include detailed processing instructions in the Inquiry field. Return the completed form to the address below. A completed form is required for each submitted claim.

SEND COMPLETED FORM TO:

Attn: Provider Services
Oklahoma Health Care Authority
PO Box 18506, Oklahoma City, OK 73154

FORM MUST BE PLACED ON TOP OF CLAIM

PROVIDER INFORMATION

Name & Address:	Provider Number: _____ Group Number (if applicable): _____ Telephone: _____ Contact Name: _____ Please print.

CLAIM INFORMATION

Member Name	Member ID Number	Date of Service	Related ICN

INQUIRY: (Please list specific reasons why claim needs/requires special processing.)

Printed Name: _____ Signature: _____	Date:

For Internal Use Only

FORM MUST BE PLACED ON TOP OF CLAIM

To reach OHCA by mail, send correspondence to the appropriate division:

ORIGINAL, RESUBMITTED, CORRECTED OR TIMELY FILED CLAIMS

Electronic Data Interchange, EDI
FKA: Electronic Media Claims
Mail tapes and diskettes to:
EDS
PO Box 54400
Oklahoma City, OK 73154

CMS-1500 Form:
EDS
PO Box 54740
Oklahoma City, OK 73154

Long Term Care Nursing Facilities:
EDS
PO Box 54200
Oklahoma City, OK 73154

Medicare Crossover, Dental (ADA Form)/Transportation Services, (CMS-1500):
EDS
PO Box 18110
Oklahoma City, OK 73154

Pharmacy:
EDS
PO Box 18650
Oklahoma City, OK 73154

Waiver provider billing for Waiver services:
EDS
PO Box 54016
Oklahoma City, OK 73154

UB 92 Form (Hospital or Home Health), Lab or DME (CMS-1500):
EDS
PO Box 18430
Oklahoma City, OK 73154

HMO Co-Pay/Personal Care (individual, not agency):
EDS
PO Box 18500
Oklahoma City, OK 73154

Requesting an adjustment to claim:
OHCA—Adjustment Unit
4545 N. Lincoln Blvd, Suite 124
Oklahoma City, OK 73105

Refunding money or returning check:
OHCA-Finance Unit
PO Box 18299
Oklahoma City, OK 73154

Sending a written inquiry with copy of claim:
OHCA—Customer Service
PO Box 18506
Oklahoma City, OK 73154

Visit the Oklahoma Health Care Authority website at: http:/www.okhca.gov/general/links/gencontinfo_helptel.htm to obtain additional information on the OHCA contact telephone numbers and mailing addresses.

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Request for Duplicate Provider Remittance Statement

Please complete one form per request and include $5.00 non-cash payment per request if the Remittance Statement is beyond 60 days or if requesting a copy of the electronic Remittance Statement. Mail completed form(s) and payment to:

Oklahoma Health Care Authority
ATTN: Central Files
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Provider Name (Last, First, MI): _____
*Provider Billing Number: _____
Mailing Address (with zip code): _____
_____
Contact Person: _____
Telephone Number (with extension): _____

Paid Claims: (Complete A or B)

A.
Warrant #: _____
Issue Date: _____
Warrant Amount: _____
*Pay to Provider Number: _____

B.
Deposit Date: _____
Deposit Amount: _____
*Pay to Provider Number: _____

Denied Claims:
Medicaid Client ID #: _____
*Pay to Provider Number: _____
Date of Service: _____
Date of Denial: _____

If you filed your claim via Electronic Media (EMC), please include EMC transmittal #: _____

*** Provider Numbers as of Date of Service**

Incomplete requests will be returned.
As stated under the Federal Privacy Act, information will not be released to collection agencies.

Please allow 3-4 weeks for response.

Agency Use:
Date Received/Initial: _____/__
Date Completed: _____
Check Number: _____
Mailed: _____

STATE OF OKLAHOMA
Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105 (405) 522-7300

Authorization to Release Medicaid Records

Client Name:_____ **Client ID#:**_____ **DOB:**_____

1. I authorize the OHCA to release the above individual's Medicaid information as described below.

2. I understand the information in my Medicaid record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. This information may be released to the following:
   Name:_____
   Address:_____
   Phone:_____ FAX:_____

4. For the purpose of:

5. I understand that I can change this authorization at any time. I understand that I must change this authorization in writing to OHCA. I understand that information may have already been released based on this authorization. Unless changed, this authorization will expire on the following date:_____. If I don't put a date, this authorization will expire in six months.

6. I understand that signing this release is voluntary, and a refusal to sign does not affect my receipt of Medicaid services. I may inspect or obtain a copy of the information to be released.

Under penalty of law, I represent that I am, in fact, the undersigned, or his/her legal representative.

Signature of Patient or Legal Representative *(Legal representative must show relationship to patient):*

X_____ Date:_____

*Relationship to patient:*_____

Signature of Witness

X_____ Date:_____

STATE OF OKLAHOMA
Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105 (405) 522-7300

Autorización para revelar el expediente médico

Nombre del cliente: _____ # de ident: _____ Fecha de nacimiento: _____

1. Autorizo a la OHCA a revelar la información de Medicaid del individuo cuyo nombre aparece arriba como se describe abajo.

2. Entiendo que la información en mi récord de Medicaid puede incluir información relacionada con enfermedades transmitidas sexualmente, síndrome de inmunodeficiencia adquirida (SIDA), o virus de inmunodeficiencia humana (HIV). También puede incluir información sobre servicios médicos de comportamiento o problemas mentales, y tratamiento contra el abuso de alcohol y drogas.

3. Esta información puede ser revelada a:
   Nombre: _____
   Dirección: _____
   Tel: _____ FAX: _____

4. Para propósitos de:

5. Entiendo que puedo cambiar esta autorización en cualquier momento y que si deseo cambiarla debo hacerlo por escrito a la OHCA. Entiendo que la información podría ya haber sido revelada en base a esta autorización. A menos que se cambie, esta autorización expirará en la fecha: _____. Si no escribo una fecha, esta autorización expirará en seis meses.

6. Entiendo que mi firma en esta autorización es voluntaria, y el que no la firme no afecta que yo siga recibiendo servicios de Medicaid. Puedo inspeccionar u obtener una copia de la información que puede ser revelada.

Bajo pena de ley, represento que soy, realmente, el que firma, o su representante legal.

Firma del paciente o representante legal *(El representante legal debe mostrar su relación con el paciente):*

X _____ Fecha: _____

Relación con el paciente: _____

Firma del testigo

X _____ Fecha: _____

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Care Management Referral Form

Care Management Phone: 1-877-252-6002 **Care Management Fax: 405-530-3217**

Referral Date:		**Date Care Mgmt Referral Received:**	
		Received by:	
		Referral Source Notified of Receipt:	☐ **Yes**

Referral Information

Referral Source:
☐ Primary Care Provider ☐ Caseworker/DC Planner
☐ Specialty Provider ☐ Community Agency
☐ ER Department ☐ Other (define:)

Referral Name: **Referral Phone:**

Recipient Information

Recipient Name: Recipient ID:
Recipient DOB: Recipient Phone:
Contact Name: Contact Phone:
Relationship to Recipient: ☐ Self ☐ Family ☐ Other (specify)

Additional information:

Reason for Referral

☐ Coordinate complex case
☐ Access primary care services
☐ Multiple ER visits
☐ Access community resources
☐ Education needs related to condition
☐ Education needs related to benefits
☐ Multiple inpatient admissions
☐ Follow-up of complex inpatient admission
☐ Complex discharge needs
☐ Poly-pharmacy
☐ Other

Description of referral reason:

Medicare-Medicaid Crossover Invoice

ONE INVOICE PER CLAIM

Header 1	
SoonerCare Provider ID:	
Member ID	Member Name First: Last:
Patient Control Number	
Medicare HIC Number	
From DOS: To DOS:	

Header 2	
Total Billed: $	
Date Paid:	
Coinsurance: $	Medicare Remark Code :
Deductible: $	Medicare Remark Code :
Blood Deductible: $	
Total Allowed: $	Medicare Remark Code :
Medicare Remark Code :	
Amount Paid: $	Medicare Remark Code :

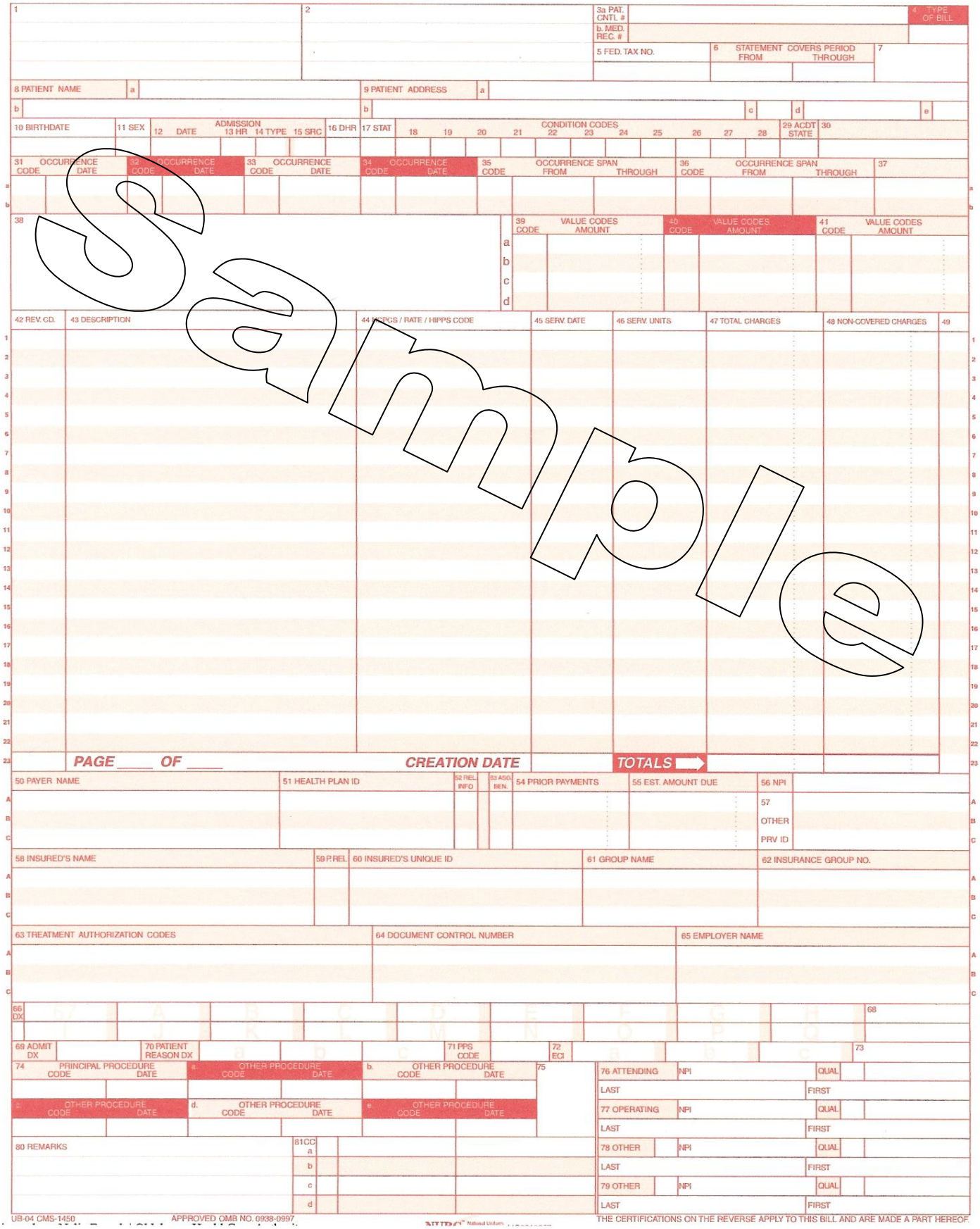
Mail claims for payment to:
EDS
P.O. Box 18110
Oklahoma City, OK 73154

Provider Signature Date Signed

Medicare-Medicaid Crossover Invoice

Field Description for Medicare-Medicaid Crossover Invoice

Form Locator	HCA – 28 Form
Sooner Care Provider ID:	Enter the 10-character Oklahoma SoonerCare provider number of the Billing Provider. *Required.*
Member ID	Enter the member's SoonerCare identification number. Must be nine digits. *Required.*
Patient Control Number	Patient's Account Number – Enter your internal patient tracking number. The tracking number should be the same as the submitted claim. *Optional.*
Medicare HIC Number	Enter the Patient's Medicare HIC Number. The Medicare HIC Number should be the same number as submitted on the claim. *Required.*
Dates of Service	Enter the From and To Dates of Service as MM/DD/YYYY. *Required.*
Total Billed	Enter the Amount Billed from the Medicare Explanation of Benefits. *Required.*
Date Paid	Enter the Date Paid as MM/DD/YYYY from the Medicare Explanation of Benefits. *Required.*
Coinsurance	Enter the Coinsurance Amount from the Medicare Explanation of Benefits. *Required, if applicable.*
Coinsurance Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable.*
Deductible	Enter Deductible Amount from the Medicare Explanation of Benefits. *Required, if applicable.*
Deductible Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable.*
Blood Deductible	Enter the Blood Deductible from the Medicare Explanation of Benefits. *Required, if applicable*
Total Allowed	Enter the Amount Allowed from the Medicare Explanation of Benefits. *Required, if applicable.*
Total Allowed Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable.*
Amount Paid	Enter the Amount Paid from the Medicare Explanation of Benefits. *Required, if applicable.*
Amount Paid Remark Code	Only enter Remarks PR-122 or MA 67. *Required, if applicable.*
Provider Signature	Signature of Physician or Supplier– The name of the authorized person, someone designated by the agency or organization. *Required.*
Date Signed	Enter date the claim was signed as MM/DD/YYYY. *Required*


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 ADMISSION DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 CODE OCCURRENCE SPAN FROM THROUGH
36 CODE OCCURRENCE SPAN FROM THROUGH
37
38
39 CODE VALUE CODES AMOUNT
40 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67 68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC
UB-04 CMS-1450 APPROVED OMB NO. 0938-0997
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization

☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(a)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) –	52A. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code
57. Phone Number ( ) –	58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

State of Oklahoma

Oklahoma Health Care Authority

SoonerCare/OEPIC IP Referral Form

Please Print
Member Name

Last Name | First Name | Middle Initial

Member ID# (nine digits)

Member Phone #

Referred To:

Provider Name (Must be a current Medicaid Provider)

Provider Phone #

Provider Address

PCP/CM Referral Valid for (check one)

☐ Initial Visit Only

☐ Evaluation & Treatment for _____ months (cannot exceed 12 months)

Diagnosis (Use ICD-9 Codes)	1	2	3

Reason for Referral:

Referred by:

Primary Care Provider/ Case Manager Name

PCP/CM Phone #

Signature of Referring Provider

Date

PCP/CM # Referral Number (ten digits)

NPI #

* This referral is valid for all ancillary services related to the above diagnosis within the specified time frame.
* This referral may be forwarded to other specialists for the above diagnosis with the approval of the PCP/CM.
* Report your findings directly to the provider who made this referral.
* This referral number should be entered by the referred to provider in Block 17a and NPI in Block 17b of the CMS-1500 claim form or Block 83B of the UB 92 claim form.
* This form is for referral only. It does not replace the prior authorization form. Some services for ***SoonerCare/OEPIC IP*** clients require (1) PCP/CM referral **and** (2) prior authorization from the Medical Authorization Unit at Oklahoma Health Care Authority. The current prior authorization policies are unchanged (See Oklahoma Health Care Authority Rules).
* All payments for services are subject to coverage limitations under the current Medicaid/OEPIC IP program and the referral is not a guarantee of payment.

Instructions:

1. Complete and mail the original copy of the form to the provider to whom you are referring.
2. Keep a duplicate copy for your records in the member's medical chart.
3. Referral form (SC-10) may be obtained on the OHCA web site at http://www.okhca.org/provider/forms.asp

PLEASE DO NOT MAIL OR FAX A COPY TO OHCA.
PLEASE DO NOT ATTACH A COPY TO YOUR CLAIM FORM.

State Of Oklahoma
Oklahoma Health Care Authority

Attention SoonerCare Helpline: Fax: (405) 782-8780

Provider Representative's Name:_____ Urgent Request: Yes___NB___OB: Yes____

SoonerCare
Provider Change Request Action Form

Please use this form when requesting a change in your/your family's SoonerCare primary care provider. Members age 14 and over may choose general practice, family practice or internal medicine providers. For children under age 14 you may choose pediatricians, family medicine or general practice providers. You may change your provider up to four times per year.

1. **Complete the form below. Be sure to include all information requested including your Medicaid ID number. Incomplete forms may result in your change being delayed.**
2. **The member must sign this form. Your provider can not sign this form for you.**
3. **Return the completed form to your health care provider. They will fax the form to SoonerCare for you.**

Enrollment changes may take up to 45 days. If you have questions about your PCP change, please contact the SoonerCare Helpline at 1-800-987-7767
Providers: Please make sure your name and provider number is on the form and correct. Fax this form to SoonerCare Helpline at 405-782-8780.

Please Print:

Name of family member Changing PCP/CM	SoonerCare ID Number	Birth Date (required) mm/dd/year	Social Security Number	Name of new Provider	Primary Care Provider Number	OB Estimated Date of Delivery

Your address:_____Apt.#____City_____State_____Zip_____

Member Signature_____ Phone number or message phone_____

For Provider Representative Use Only: Date Received_____Urgent Request_____Disenrollment Date_____
Check all that apply: Panel hold_____ Age Restriction_____Supervisor Approval_____

For Member Services Use Only: Reason not processed _____ Panel hold on: _____Age Restriction on _____
Date Received_____Completed By_____Date Completed_____ Panel hold off: _____Age Restriction off _____

SoonerCare Helpline Use Only:
Date Received: _____Completed by:_____Reason not Processed: _____